

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6464
CERTIFICATE OF DEATH

06423
216

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | c. LENGTH OF STAY IN 1b 20 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 6218 - 27th Street, North | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Virginia Middle Madlyn Last Abernathy | | 4. DATE OF DEATH Month June Day 17 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 15, 1912 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Hospital | 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ |
| 11. BIRTHPLACE (State or foreign country) California | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George Smith | | 14. MOTHER'S MAIDEN NAME Lynette Heuser | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Unascertainable | |
| 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Melanoma in Brain, Lungs 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Liver Heart Kidneys DUE TO (c) Malignant Melanoma | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 600.0 Pylonephritis due to E. coli | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 28 , 19 57 , to June 17 , 19 57 , that I last saw the deceased alive on June 17 , 19 57 , and that death occurred at 7 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur J. Garceau M.D. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) Arthur J. Garceau, M. D. | | DATE SIGNED 6/18/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF JUNE 21 - 1957 | 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM. | 22d. LOCATION (City, town, or county) (State) ARLINGTON VIRGINIA |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington Funeral Home | | 24a. REC'D BY REGISTRAR JUN 21 1957 | |
| ADDRESS 3901 W. Fairfax Rd. Arlington VA | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

6465

CERTIFICATE OF DEATH

06424

Reg. Dist. No. 216

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 67 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville 70x-3 | |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Clarissa Last Albert | | 4. DATE OF DEATH Month June Day 27 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 16 December 1919 |
| 9. AGE (In years last birthday) 37 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 11 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William D. Morse | | 14. MOTHER'S MAIDEN NAME Clarissa Tyler | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WWII | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive FAILURE 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral INSUFFICIENCY DUE TO (c) Rheumatic fever | | INTERVAL BETWEEN ONSET AND DEATH known 6 months years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 21 April , 19 57 , to 27 June , 19 57 , that I last saw the deceased alive on 27 June , 19 57 , and that death occurred at 11:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 6/28/57 | | | |
| ACTUAL SIGNATURE Richard J. Sanders M.D. | | | |
| PHYSICIAN'S NAME (Type) Richard J. Sanders, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 6/28/57 | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY Walnut Hill | 22d. LOCATION (City, town, or county) (State) Baraboo, Wisconsin |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR 630-57 | 24b. REGISTRAR'S SIGNATURE Bessie W. Thompson |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|--------------------|--|--------------------------|--|----------------|--|-----------------|--|-------------------|--|-------------------|--|--------------------|--|-------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1910 | | New York City | | New York City | | Heart Disease | | Jan 15, 1957 | | 10:00 AM | | Home | | J. Doe, M.D. | | J. Doe, M.D. | |
| Occupation | | Marital Status | | Previous Illnesses | | Date of Last Examination | | Date of Death | | Date of Burial | | Place of Burial | | Date of Interment | | Place of Interment | | Date of Cremation | | Place of Cremation | | Date of Disposition | |
| Teacher | | Married | | None | | Jan 1, 1956 | | Jan 15, 1957 | | Jan 15, 1957 | | Catholic Cemetery | | Jan 15, 1957 | | Catholic Cemetery | | None | | None | | None | |

BUREAU V. B.

JUL 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06425

6466

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN IB 15 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Annie= Middle Allnutt Last Allnutt | | 4. DATE OF DEATH Month June Day 10 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/2/93 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George E. Brown | | 14. MOTHER'S MAIDEN NAME Jennie Young | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Hospital Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease 10 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 433.0 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/26 , 19 57 , to 6/9 , 19 57 , that I last saw the deceased alive on 6/9 , 19 57 , and that death occurred at 12:30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A. D. Bonifant, M. D. Sandy Spring, Maryland 6/10/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 12 | |
| 22c. NAME OF CEMETERY OR CREMATORY Montgomery Methodist | | 22d. LOCATION (City, town, or county) (State) Clagettville Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber | | 24a. REC'D BY REGISTRAR DATE 6/13/57 | |
| 24b. REGISTRAR'S SIGNATURE Benjamin B. Lawler | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|----------------------------|--|----------------------------|--|------------------------|--|-------------------------------|--|---------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | |
| JAMES A. BROWN | | M | | 45 | | W | | 1912 | | BALTIMORE, MD | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 1957 | | 10:00 AM | | HOME | | HEART DISEASE | | NATURAL | | J. A. BROWN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF CLERK | | 16. SIGNATURE OF CHURCH CLERK | | 17. SIGNATURE OF MINISTER | | 18. SIGNATURE OF BURIAL CLERK | |
| J. A. BROWN | | J. A. BROWN | | J. A. BROWN | | J. A. BROWN | | J. A. BROWN | | J. A. BROWN | |

BUREAU V. 3

JUN 21 1957

RECEIVED

DAYTONVILLE, MO

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

M

6467

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06426
218

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montg MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN 1b 15yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg x 2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Maggie Middle Brown Last Althoff | | | 4. DATE OF DEATH Month June Day 21 Year 19 57 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 13-1869 | 9. AGE (In years last birthday) 87 yrs. | IF UNDER 1 YEAR Months 9 Days 8 IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home Work | | 11. BIRTHPLACE (State or foreign country) Culpepper.Va. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME John Thomas Brown | | |
| 14. MOTHER'S MAIDEN NAME Susan Jane Edwards | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Address Gaithersburg Asbury Methodist Home Records. Md | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 6/21/57 | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REBURY (Type) Burial | | 22b. DATE THEREOF 6-24-57 | | 22c. NAME OF CEMETERY OR CREMATORY Fair View | |
| 22d. LOCATION (City, town, or county) Culpepper. | | (State) Va. | | 23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner | |
| ADDRESS Gaithersburg. Md. | | 24a. REC'D BY REGISTRAR DATE June 22-57 | | 24b. REGISTRAR'S SIGNATURE Abner G. Cooke | |

WESTLAND STATE DEPARTMENT OF HEALTH - CALIFORNIA
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|----------------|--|-------------------------------|--|-----------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Race | | Date of Death | | Place of Death | |
| John Doe | | Male | | 35 | | White | | 1957 | | Los Angeles | |
| Occupation | | Cause of Death | | Manner of Death | | Signature of Examiner | | Signature of Coroner | | Signature of Physician | |
| Teacher | | Heart Disease | | Natural | | [Signature] | | [Signature] | | [Signature] | |
| Residence | | Date of Birth | | Date of Admission to Hospital | | Date of Discharge | | Date of Death | | Date of Burial | |
| 123 Main St | | 1922 | | 1957 | | 1957 | | 1957 | | 1957 | |
| City | | County | | State | | Country | | Continental | | Island | |
| Los Angeles | | Los Angeles | | California | | United States | | North America | | Other | |
| Hospital | | Physician | | Nurse | | Attending Physician | | Pathologist | | Forensic Pathologist | |
| St. Mary's | | Dr. Smith | | Mrs. Jones | | Dr. Brown | | Dr. White | | Dr. Black | |
| Room | | Bed | | Ward | | Room | | Bed | | Ward | |
| 101 | | 10 | | 10 | | 10 | | 10 | | 10 | |
| Floor | | Room | | Ward | | Room | | Ward | | Room | |
| 1st | | 101 | | 10 | | 10 | | 10 | | 10 | |
| City | | County | | State | | Country | | Continental | | Island | |
| Los Angeles | | Los Angeles | | California | | United States | | North America | | Other | |

BUREAU Y. M.

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06427

6468

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Colorado b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 18 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Herman Middle Last Appel | | | | 4. DATE OF DEATH Month June Day 9 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 1879 | | 9. AGE (In years last birthday) 77 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar Maker (Retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY Manufacturing | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 13. FATHER'S NAME Louis Appel | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 17. INFORMANT Leonard Appel 4004 Virgilia, Chevy Chase, Md. | | | |
| 16. SOCIAL SECURITY NO. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) PULMONARY EMBOLI, RECURRENT INTERVAL BETWEEN ONSET AND DEATH 10 YEARS 4 WEEKS 3 WEEKS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from MAY 1 , 19 57 , to JUNE 9 , 19 57 , that I last saw the deceased alive on JUNE 9 , 19 57 , and that death occurred at 7 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6921-CLAREDON Rd. Bethesda, Md. DATE SIGNED 6-13-57 | | | | | | | |
| ACTUAL SIGNATURE Philip R. James | | | | M.D. 6921-CLAREDON Rd. Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) Philip R. James | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/13/57 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Nebo Cemetery | | 22d. LOCATION (City, town, or county) (State) Denver, Colorado | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Wargensky & Sons | | | | ADDRESS 3501 14th St., N. W. | | 24a. REC'D BY REGISTRAR DATE 6-13-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6435
CERTIFICATE OF DEATH

06428

Reg. Dist. No. 223

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | |
| c. LENGTH OF STAY IN 1b <u>14 days</u> | | | | d. STREET ADDRESS <u>1602 Easley St.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Marie</u> Last <u>Bakersmith</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u> | | | |
| 5. SEX <u>Fe</u> | | 6. COLOR OR RACE <u>Cauc</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>AUG. 18, 1900</u> | |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Am. Forestry Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Barnes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Turner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>578-01-1253</u> | | 17. INFORMANT <u>hosp Records</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary anemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> 581.1 DUE TO (b) <u>hemorrhage from Esophageal Varices</u> <u>3 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Cirrhosis of Liver (Laennec's)</u> <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis & Cystitis; Glomerulonephritis; Nephrolithiasis</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>January</u> , 19 <u>53</u> , to <u>June 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>57</u> , and that death occurred at <u>2:20</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive Silver Spring, Md.</u> DATE SIGNED <u>6/19/57</u> ACTUAL SIGNATURE <u>N.C. Shoemaker, M.D.</u> PHYSICIAN'S NAME (Type) <u>N.C. SHOEMAKER, M.D.</u> <u>Silver Spring, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/20/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u> | | | | 24a. REC'D BY REGISTRAR <u>6/19/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. R.

JUN 21 1957

RECEIVED

6469

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 2 months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp. | | | | e. STREET ADDRESS 4833 Broad Brook Drive | | | |
| 3. NAME OF DECEASED (Type or print) First Victor Middle Stanislaus Last Baril | | | | 4. DATE OF DEATH Month June Day 23 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 27, 1899 | |
| 9. AGE (In years last birthday) yrs. 57 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist | | | | 10b. KIND OF BUSINESS OR INDUSTRY Dept. of Labor | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Archie Baril | | | | 14. MOTHER'S MAIDEN NAME Victoria Brisson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Margaret Baril Address Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 521X (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lung Abscess, Right lower lobe | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from Jan 5, 1957 , to June 23, 1957 , that I last saw the deceased alive on June 23, 1957 , and that death occurred at 6:50 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Dr. Joseph Kenrick | | | | ADDRESS (Street, city or town, state) 6450 Wisconsin Ave, Bethesda Md 4/23/57 | | | |
| PHYSICIAN'S NAME (Type) DR. JOSEPH KENRICK | | | | DATE SIGNED 6/23/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/27/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR 6-24-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|---------------|--|
| Name of Deceased | | John Doe | |
| Sex | | Male | |
| Age | | 45 | |
| Date of Birth | | Jan 1, 1912 | |
| Place of Birth | | New York | |
| Occupation | | Teacher | |
| Cause of Death | | Heart Disease | |
| Date of Death | | Nov 27, 1957 | |
| Place of Death | | Home | |
| Signature of Physician | | [Signature] | |
| Signature of Registrar | | [Signature] | |
| Date of Registration | | Dec 1, 1957 | |
| Place of Registration | | Baltimore | |

BUREAU V. 1

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6470

CERTIFICATE OF DEATH

Reg. Dist. No.

06430

211

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Purdu | c. LENGTH OF STAY IN 1b Life | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Purdu | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS Monrovia Rfd | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Mary Frances Beall | | 4. DATE OF DEATH June 18 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec, 28 1865 |
| 9. AGE (In years lost birthday) 91 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Benjamin Franklin Burdette | | 14. MOTHER'S MAIDEN NAME Charity Ane Watkins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) #### (If yes, give year or date of service) #### | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Mrs. Emma E. Beall Address Monrovia R.F.D. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 450.0 | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 days 20 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury | |
| 20c. TIME OF INJURY Hour o. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from January , 19 35 , to June 18 , 19 57 , that I last saw the deceased alive on June 18 , 19 57 , and that death occurred at 11:45 P.M. ADDRESS (Street, city or town, state) Druid Theatre Building DATE SIGNED June 19, 1957 ACTUAL SIGNATURE M. McKendree Boyer, M.D. PHYSICIAN'S NAME (Type) Dr. McKendree E. Boyer Damascus Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 21 57 | 22c. NAME OF CEMETERY OR CREMATORY Mountain View | 22d. LOCATION (City, town, or county) (State) Purdu Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Boyer-Scarber ADDRESS Laytonsville, Md. | | 24a. REC'D BY REGISTRAR DATE June 21 57 | 24b. REGISTRAR'S SIGNATURE Della W. Burdett |

JUN 27 1957

RECEIVED

6471

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|----------------------------------|--|--|--|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> | | | |
| 5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. LENGTH OF STAY IN 1b <u>1615.2</u> ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marlen Nursing Home</u> | | | | d. STREET ADDRESS <u>2028-Powhatan Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ANN M KATHARINA BECK</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 19 1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 28, 1891</u> | 9. AGE (In years last birthday) yrs. <u>65</u> | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Kornel Weiss</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marie Louis Gottschling</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>450.0</u> | | 17. INFORMANT <u>Mrs. Emma Noble</u> | | Address <u>Niece</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lethal vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>terminal arteriosclerosis</u> DUE TO (c) <u>hypertension</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>July 10, 1956</u> , to <u>June 19, 1957</u> , that I last saw the deceased alive on <u>June 15, 1957</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert D. Rogers</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1519 Seminary Rd. Silver Spring, Md.</u> | | | |
| DATE SIGNED <u>6-19-57</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>June 21, 1957</u> | | <u>Arlington National</u> | | <u>Washington, Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Tom Lee & Sons</u> | | | | ADDRESS <u>Washington DC</u> | | 24a. REC'D BY REGISTRAR <u>DATE 6-24-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Beauie M. Thompson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint, illegible handwriting.

BUREAU V. 3

JUN 26 1957

RECEIVED

6436

CERTIFICATE OF DEATH

Reg. Dist. No.

773

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | | c. LENGTH OF STAY in 1b <i>17 days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hosp</i> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> <i>1615.2</i> | | | |
| f. STREET ADDRESS <i>5720 29th Ave Apt 102</i> | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Lee</i> Last <i>Bell</i> | | | | 4. DATE OF DEATH Month <i>6</i> Day <i>6</i> Year <i>1957</i> | | | |
| 5. SEX <i>Fe</i> | | 6. COLOR OR RACE <i>CoCc</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>7-7-79</i> | |
| 9. AGE (In years last birthday) <i>77</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hsfi</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>V9</i> | | | |
| 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Jesse Ruffner</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Emma Ball</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>Hosp Records</i> | | | |
| 17. INFORMANT Address <i>Hosp Records</i> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gastro-intestinal hemorrhage</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of pancreas</i> DUE TO (c) <i>months</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>April 25, 1957</i> , to <i>June 6, 1957</i> , that I last saw the deceased alive on <i>June 5, 1957</i> , and that death occurred at <i>7:45 AM</i> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <i>7105 Riggs Rd. Hyattsville, Md.</i> | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>6/8/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery Prince George County, Md.</i> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> | | | | 24a. REC'D BY REGISTRAR <i>2901 14th St. N.W. Washington, D.C.</i> | | | |
| 24b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | DATE <i>JUN 7 1957</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| NAME OF DECEASED <i>John Doe</i> | | MARRIAGE <i>Married</i> | |
| AGE <i>45</i> | | SEX <i>Male</i> | |
| DATE OF DEATH <i>June 2, 1957</i> | | PLACE OF DEATH <i>Home</i> | |
| CAUSE OF DEATH <i>Heart Disease</i> | | MANNER OF DEATH <i>Natural</i> | |
| DATE OF BIRTH <i>June 2, 1912</i> | | PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| FATHER'S NAME <i>John Doe</i> | | MOTHER'S NAME <i>John Doe</i> | |
| OCCUPATION <i>Teacher</i> | | EDUCATION <i>High School</i> | |
| RELIGION <i>Catholic</i> | | MARITAL STATUS <i>Married</i> | |
| DATE OF DEATH <i>June 2, 1957</i> | | PLACE OF DEATH <i>Home</i> | |
| CAUSE OF DEATH <i>Heart Disease</i> | | MANNER OF DEATH <i>Natural</i> | |
| DATE OF BIRTH <i>June 2, 1912</i> | | PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| FATHER'S NAME <i>John Doe</i> | | MOTHER'S NAME <i>John Doe</i> | |
| OCCUPATION <i>Teacher</i> | | EDUCATION <i>High School</i> | |
| RELIGION <i>Catholic</i> | | MARITAL STATUS <i>Married</i> | |

BUREAU V. 1

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6472

Item 1 Film G217 6-20-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06433

214

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN 1b 2 Months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First RUSSELL Middle M. Last BEVLIN | | 4. DATE OF DEATH Month 6 Day 9 Year 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAR. 12, 1900 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Cab Driver | | 10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 579-22-1228 | |
| 17. INFORMANT Silver Spring, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Coronary sclerosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH sudden 1 year 2 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 10, 1955 to June 9, 1957 , that I last saw the deceased alive on June 8, 1957 , and that death occurred at 11:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6234 2nd Ave NW Washington D.C. 47/57 DATE SIGNED ACTUAL SIGNATURE Daniel B. Washington M.D. PHYSICIAN'S NAME (Type) Daniel B. Washington M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-12-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL | | 22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins | | 24a. REC'D BY REGISTRAR Francis J. Collins | |
| 24b. REGISTRAR'S SIGNATURE Francis J. Collins | | 24c. DATE JUN 12 1957 | |

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| NAME OF DECEASED JAMES EARL RAY | | DATE OF DEATH JUN 12 1968 | |
| AGE 35 | | SEX MALE | |
| RACE WHITE | | BIRTH DATE MAY 19 1933 | |
| PLACE OF BIRTH MEMPHIS, TENN. | | OCCUPATION BUSINESSMAN | |
| EDUCATION HIGH SCHOOL | | MARRIAGE MAY 19 1968 | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | |
| SIGNATURE OF PHYSICIAN JAMES EARL RAY | | SIGNATURE OF DECEASED JAMES EARL RAY | |
| SIGNATURE OF WITNESS JAMES EARL RAY | | SIGNATURE OF WITNESS JAMES EARL RAY | |

BUREAU V. 1

JUN 12 1968

RECEIVED

6473

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | |
|---|--|--------------------------------------|--|--|--|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY Montgomery MARYLAND | | | STATE Maryland COUNTY Montgomery | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | |
| TOWN Silver Spring | | | TOWN Silver Spring | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 10,203 Brookmoor Drive | | | STREET ADDRESS (If rural give location) 10,203 Brookmoor Drive | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) Julian William Bieber | | | 4. DATE OF DEATH: (Month) (Day) (Year) June 9 19 57 | | |
| 5. SEX: male | | 6. COLOR OR RACE: white | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced | |
| 8. DATE OF BIRTH: July 10, 1899 | | 9. AGE last birthday: 57 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Carpenter | | | 10b. KIND OF BUSINESS OR INDUSTRY: Building | | |
| 11. BIRTHPLACE (State or foreign country): D. C. | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME: Henry J. Bieber | | | 14. MOTHER'S MAIDEN NAME: Lissetta R. Huth | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No | | | 16. SOCIAL SECURITY No.: 214-03-9439 | | |
| 17. INFORMANT & ADDRESS: Mrs. Carlotta B. Jackson, 10,203 Brookmoor Dr. | | | | | |

| | | |
|---|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | Interval Between Onset And Death |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| Immediate cause (a) Cerebral thrombosis | | 3 weeks |
| Antecedent causes (s) (b) DUE TO | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO | | |

| | | |
|---|---|---|
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY m. | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **May 17, 1957**, to **June 9, 1957**, that I last saw the deceased alive on **June 3, 1957** and that death occurred at **3:00 am**, from the causes and on the date stated above.

SIGNATURE (Degree or title) **A. F. Thibodeau M.D.** ADDRESS **10111 Coleville Rd. Silver Spring Md.** DATE SIGNED **6/9/57**

| | | | |
|--|---|---|---|
| 23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF June 11, 1957 | NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery | LOCATION (City, town, or county) (State) Washington, D. C. |
| DATE REC'D BY LOCAL REGISTRAR 6-17-57 | REGISTRAR'S SIGNATURE Frances Potter | 24. FUNERAL DIRECTOR Warner E. Pumphrey | ADDRESS Silver Spring, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6474

CERTIFICATE OF DEATH

06435

Reg. Dist. No. 216

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | c. LENGTH OF STAY IN 1b 10 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 ✓ | |
| d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md. | | d. STREET ADDRESS 635 Otis Place, N.W. | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Benjamin Middle (No middle name) Last Blake | 4. DATE OF DEATH Month June Day 30 Year 19 57 | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH March 6, 1912 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Government | 11. BIRTHPLACE (State or foreign country) North Carolina |
| 13. FATHER'S NAME Gilbert Blake | | 14. MOTHER'S MAIDEN NAME Annie (Last name unknown) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II | | 16. SOCIAL SECURITY NO. Not available | |
| 17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md. | | | |

| | | | |
|--|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic Glomerulonephritis DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 10 days unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443x Hypertensive Cardiovascular Disease | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 20, 1957 , to June 30, 1957 , that I last saw the deceased alive on June 30, 1957 , and that death occurred at 7:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 6/30/57 | | | |
| ACTUAL SIGNATURE P. Roy Vagelos | | M.D. The Clinical Center | |
| PHYSICIAN'S NAME (Type) P. Roy Vagelos, M.D. | | National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 7-5-1957 | 22c. NAME OF CEMETERY OR CREMATORY Carlington Nat Cemetery | 22d. LOCATION (City, town, or county) (State) Virginia VA. |
| 23. FUNERAL DIRECTOR'S SIGNATURE CORNISH + Cornish | | 24a. REC'D BY REGISTRAR JUL 5 1957 | |
| ADDRESS 2121-10-St N.W. | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 5 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06436

6475

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1520 EAST-WEST HIGHWAY | | d. STREET ADDRESS 1520 EAST-WEST HIGHWAY | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First IDA Middle McINTOSH Last BOONE | | 4. DATE OF DEATH Month JUNE Day 15 Year 1957 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 13, 1883 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) registered nurse - retired | | 10b. KIND OF BUSINESS OR INDUSTRY Mississippi | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN A. McINTOSH | | 14. MOTHER'S MAIDEN NAME JANE CARLOS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Miss Minnie B. McIntosh, 1520 East-West Highway Silver Spring, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease 416X DUE TO 40 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO 4 years (c) Congestive Heart Failure DUE TO 4 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200 Generalized Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 1, 1956 to June 15, 1957 , that I last saw the deceased alive on June 15, 1957 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 6/15/57 ACTUAL SIGNATURE John J. Curry M.D. John J. Curry PHYSICIAN'S NAME (Type) JOHN J. CURRY | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 6/16/57 | | 22b. DATE THEREOF 6/16/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State) MEMPHIS, TENNESSEE | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey | | 24a. REC'D BY REGISTRAR 6/17/57 | |
| 24b. REGISTRAR'S SIGNATURE Kanas Potter | | | |

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BUREAU V. 2.

JUN 19 1957

RECEIVED

6437

CERTIFICATE OF DEATH

Reg. Dist. No.

773

| | | | | | | | |
|--|-------------------------------|--|---------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt 11, 232</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Soc. & Hosp.</u> | | | | d. STREET ADDRESS <u>6 E. Ridge Road.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Jeffrey</u> First <u>Beacham</u> Middle <u>Breasteads</u> Last | | 4. DATE OF DEATH <u>6</u> - <u>14</u> - <u>1957</u> Month Day Year | | | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-9-55</u> | 9. AGE (In years last birthday) <u>1</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Royal Dolan Breasteads</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Vera Beacham</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Chart</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Viral hepatitis</u> <u>583x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/9</u> 19 <u>55</u> , to <u>6/14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6/14</u> 19 <u>57</u> and that death occurred at <u>6:35</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Charles Farwell</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>12126 Views Mac Rd - 9/14/57</u> DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>CHARLES FARWELL</u> <u>Washington Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) | | 22b. DATE THEREOF <u>6/15/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u> | | 22d. LOCATION (City, town, or county) (State) <u>Kitty Hawk, N.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u> | | ADDRESS <u>5801 Churchland Ave</u> | | 24a. REC'D BY REGISTRAR <u>J. Wilson, Daddy</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6476

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06438

Reg. Dist. No. 213

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Off Md. R-355, 1 1/2 mi. W Clarksburg | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X-3 d. STREET ADDRESS 507 Rossiter St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Carl Ross Burke First Middle Last | | 4. DATE OF DEATH 6/22/57 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/10/1925 |
| 9. AGE (In years last birthday) 32 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot | | 10b. KIND OF BUSINESS OR INDUSTRY Airline Transport | |
| 11. BIRTHPLACE (State or foreign country) Arizona | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Spencer A. Burke | | 14. MOTHER'S MAIDEN NAME Mary E. Ross | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 567-26-0311 | |
| 17. INFORMANT Capital Airline Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries, Extreme DUE TO (b) Body & Extremities badly Mutilated DUE TO (c) 861X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Accident | |
| 20c. TIME OF INJURY Month, Day, Year 9:00 a.m. 6/22/57 | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) country | | 20f. (City or town) (County) (State) Clarksburg Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Brosehart EXAMINER'S NAME (Type) Frank J. Brosehart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/22/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 25, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | 22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Everly Funeral Home By | | 24a. REG. DAY REGISTRAR JUN 28 1957 24b. REGISTRAR'S SIGNATURE Samuel Drayton | |

RECEIVED

JUN 28 1957

BUREAU V. S.

6477

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | c. LENGTH OF STAY IN 1b 3 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 704 McNeil Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ISAAC Middle RAYMOND Last BURTON | | | | 4. DATE OF DEATH Month JUNE Day 24 Year 19 57 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/9/86 | |
| 9. AGE (In years lost birthday) 70 yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route man (retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY Congress Laundry | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME WALTER T. BURTON | | | | 14. MOTHER'S MAIDEN NAME EDNA A. ATHINSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 578-24-7819 | | 17. INFORMANT Mrs. Elsie M. Burton, 704 McNeil Rd. Silver Spring, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aneurysm of abdominal aorta 451x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.3 Cardiac decompensation | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from 1952 to 6/24 , 19 57 , that I last saw the deceased alive on 1/22 , 19 55 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9006 Glenview Rd Silver Spring, Md DATE SIGNED 6/24/57 | | | | | | | |
| ACTUAL SIGNATURE William D. Aud M.D. | | | | PHYSICIAN'S NAME (Type) William D. Aud | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/26/57 | | 22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE CEMETERY | | 22d. LOCATION (City, town, or county) (State) BURTONSVILLE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey | | | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE 6/30/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Hances Potter | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|------------------------------|--|---------------------------|--|---------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES E. SMITH | | 45 | | M | | W | | 1912 | | BALTIMORE | | MD | | USA | | USA | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | |
| JUL 10 1957 | | 10:30 AM | | HOME | | BALTIMORE | | MD | | USA | | HEART DISEASE | | NATURAL | | 12345 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF BURIAL OFFICIAL | | SIGNATURE OF FUNERAL HOME | | SIGNATURE OF CHURCH | | SIGNATURE OF OTHER | |
| J. E. SMITH | | J. E. SMITH | | J. E. SMITH | | J. E. SMITH | | J. E. SMITH | | J. E. SMITH | | J. E. SMITH | | J. E. SMITH | | J. E. SMITH | |

BUREAU V. 3

JUL 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6478

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G216 6-13-57 et

06440

Reg. Dist. No. 216

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 20 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8615 Brandt St. | | d. STREET ADDRESS 8615 Brandt St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Duncan Cameron Campbell | | 4. DATE OF DEATH June 6 1957 19 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/25/1887 |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec. officer retired | | 10b. KIND OF BUSINESS OR INDUSTRY F.H.A. | |
| 11. BIRTHPLACE (State or foreign country) Pa, | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James L. Campbell | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Rose Campbell | | Address Same as # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Carbon monoxide Poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Carbon monoxide Poisoning DUE TO (c) Carbon monoxide Poisoning INTERVAL BETWEEN ONSET AND DEATH Found dead in car at home | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in car in closed garage at home | |
| 20c. TIME OF INJURY Month, Day, Year 6/6/57 Hour 3:30 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-7-57 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Dauphin Co. Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR 6-8-57 | | 24b. REGISTRAR'S SIGNATURE Bea M. Thompson | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: James I. Campbell SEX: Male AGE: 50 YEARS
DATE OF BIRTH: 1907 PLACE OF BIRTH: Worcester, Mass.
OCCUPATION: None MARITAL STATUS: Widow
EDUCATION: High School RELIGION: None
Usual Residence: 100 North Street, Worcester, Mass.
Place of Death: Home
Cause of Death: Carbon monoxide poisoning
Manner of Death: Accident
Time of Death: 11:00 P.M. Date of Death: June 11, 1957
Signature of Medical Examiner: [Signature]
Signature of Coroner: [Signature]

BUREAU V. 2

JUN 11 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Disrriet of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 9 hours d. STREET ADDRESS 5117 Westridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Rosa Middle Lee Last Canada | | | | 4. DATE OF DEATH Month June Day 22 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 5, 1872 | |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months 8 Days 5 Hours 15 Min. | | IF UNDER 24 HRS. Months 8 Days 5 Hours 15 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired | |
| 11. BIRTHPLACE (State or foreign country) ARKANSAS | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JESSIE E MARTIN | | 14. MOTHER'S MAIDEN NAME SARAH (UNKNOWN) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 578-05-2665 | | 17. INFORMANT JOE HICKS-SON Address 415 H. Dr. 5117 Westridge Rd. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis DUE TO (c) 260x Diabetes Mellitus | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from June 19, 1955 , to June 22, 1957 , that I last saw the deceased alive on June 22, 1957 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE Michel M. Healy | | PHYSICIAN'S NAME (Type) Michel M. Healy | | ADDRESS (Street, city or town, state) Washington Circle, Washington 15 D.C. | | RATE SIGNED 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit | | 22b. DATE THEREOF 6-23-57 | | 22c. NAME OF CEMETERY OR CREMATORY Roselawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Pulaski, Arkansas | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR 6-24-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------|--|----------------------------|--|----------------------------|--|
| NAME OF DECEASED George | | SEX Male | | AGE 70 | |
| DATE OF DEATH June 26, 1957 | | PLACE OF DEATH Home | | CITY Baltimore | |
| CAUSE OF DEATH Heart Disease | | MANNER OF DEATH Natural | | PLACE OF BIRTH Maryland | |
| DATE OF BIRTH June 26, 1957 | | PLACE OF BIRTH Maryland | | CITY Baltimore | |
| NAME OF DECEASED George | | SEX Male | | AGE 70 | |
| DATE OF DEATH June 26, 1957 | | PLACE OF DEATH Home | | CITY Baltimore | |
| CAUSE OF DEATH Heart Disease | | MANNER OF DEATH Natural | | PLACE OF BIRTH Maryland | |
| DATE OF BIRTH June 26, 1957 | | PLACE OF BIRTH Maryland | | CITY Baltimore | |

BUREAU V. 2

JUN 26 1957

RECEIVED

| | | |
|---------------------------------|----------------------------|----------------------------|
| DATE OF DEATH June 26, 1957 | PLACE OF DEATH Home | CITY Baltimore |
| CAUSE OF DEATH Heart Disease | MANNER OF DEATH Natural | PLACE OF BIRTH Maryland |
| DATE OF BIRTH June 26, 1957 | PLACE OF BIRTH Maryland | CITY Baltimore |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06442

CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| <p>1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND</p> | | | | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery</p> | | | |
| <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.</p> | | <p>c. LENGTH OF STAY IN 1b less 1 hr.</p> | | <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring</p> | | <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sen + Hosp</p> | | | | <p>d. STREET ADDRESS 325 University Blvd. E.</p> | | <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>3. NAME OF DECEASED (Type or print) First JACOB Middle none Last CAPRON</p> | | | | <p>4. DATE OF DEATH Month 6 Day 17 Year 1957</p> | | | |
| <p>5. SEX MALE</p> | | <p>6. COLOR OR RACE WHITE</p> | | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH 4-9-1892</p> | |
| <p>9. AGE (In years last birthday) 65 yrs.</p> | | <p>IF UNDER 1 YEAR Months 6 Days 17 Hours 57 Min.</p> | | <p>IF UNDER 24 HRS. Months 6 Days 17 Hours 57 Min.</p> | | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Manager (Retired)</p> | |
| <p>10b. KIND OF BUSINESS OR INDUSTRY Wine + liquors</p> | | <p>11. BIRTHPLACE (State or foreign country) Va.</p> | | <p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p> | | <p>13. FATHER'S NAME Harry Leon Caplan</p> | |
| <p>14. MOTHER'S MAIDEN NAME not known</p> | | <p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No</p> | | <p>16. SOCIAL SECURITY NO. Not Known</p> | | <p>17. INFORMANT son (Irving Caplan) Address same</p> | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS + MYOCARDIAL INFARCTION DUE TO (c) 24 HRS</p> | | | | | | | <p>INTERVAL BETWEEN ONSET AND DEATH 12 HRS.</p> |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE</p> | | | | | | | <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) NONE</p> | | | | <p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) NONE</p> | | | |
| <p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19</p> | | <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p> | | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1352 UNIVERSITY LANE</p> | | <p>20f. (City or town) (County) (State) HYATTSVILLE MD</p> | |
| <p>21. I certify that I attended the deceased from 6/17, 1957, to 11:24 AM 6/19/57 that I last saw the deceased alive on 6/17, 1957, and that death occurred at 11:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state). DATE SIGNED 1352 UNIVERSITY LANE HAROLD STERLING M.D.</p> | | | | | | | |
| <p>22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p> | | | | | | | <p>22b. DATE THEREOF 6/19/57</p> |
| <p>22c. NAME OF CEMETERY OR CREMATORY Adams Memorial Co.</p> | | | | | | | <p>22d. LOCATION (City, town, or county) (State) Nashington DC</p> |
| <p>23. FUNERAL DIRECTOR'S SIGNATURE B. Danyanaby + Mrs ADDRESS 3501-142</p> | | | | | | | <p>24a. REC'D BY REGISTRAR DATE 6/10/57</p> |
| <p>24b. REGISTRAR'S SIGNATURE J. M. H. Deed</p> | | | | | | | |

MEDICAL CERTIFICATION

6480

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Prince William | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 130 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS R. D. 2 | | | |
| 3. NAME OF DECEASED (Type or print) First Clarence Middle Fitzwater Last Carrico | | | | 4. DATE OF DEATH Month June Day 1 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 28, 1925 | |
| 9. AGE (In years lost birthday) 32 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Correctional Officer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Reformatory | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME John Henry Carrico | | | | 14. MOTHER'S MAIDEN NAME Ada Angeline Fitzwater | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2 | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory paralysis DUE TO 192x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic chorocarcinoma DUE TO mos. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Days mos. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from January 22, 1957 , to June 1, 1957 , that I last saw the deceased alive on June 1, 1957 , and that death occurred at 11 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE S. Weissman M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-2-57 | | | |
| PHYSICIAN'S NAME (Type) SHERMAN WEISSMAN, M. D. | | | | National Institutes of Health Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 4 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Garden | | 22d. LOCATION (City, town, or county) (State) Manassas, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Garberson | | | | ADDRESS Hyattsville Md | | 24a. REC'D BY REGISTRAR JUN 6 1957 | |
| 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
JUN 6 1957
BUREAU V. S.

6431

CERTIFICATE OF DEATH

06444

Reg. Dist. No. 215

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 36 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Floyd Middle James Last CARTER | | | | 4. DATE OF DEATH Month June Day 19 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 7, 1893 | |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor | | 11. BIRTHPLACE (State or foreign country) North Dakota | |
| 10b. KIND OF BUSINESS OR INDUSTRY Chiropractic Physiotherapy | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME George C. CARTER | | 14. MOTHER'S MAIDEN NAME Annabelle RHODES | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 213-38-1365 | | 17. INFORMANT Wife, Elsie Beatrice CARTER (Same as #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 250.0 (b) Arterio-sclerotic Heart Disease (c) Arterio-sclerosis, generalized | | | | INTERVAL BETWEEN ONSET AND DEATH 5 to 6 weeks Indefinite Indefinite | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) 19 | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from May 14 , 1957, to June 19 , 1957, that I last saw the deceased alive on June 18 , 1957, and that death occurred at 8:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-19-57 | | | | | | | |
| ACTUAL SIGNATURE Thomas R. Ulschager M.D. | | | | PHYSICIAN'S NAME (Type) Thomas R. ULSHAFFER, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-21-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington Virginia | |
| 23. PUBLIC HEALTH DIRECTOR'S SIGNATURE R.A. Pumphrey | | | | ADDRESS 7557 Wisc. Ave., Bethesda, Md. | | 24a. REC'D BY REGISTRAR 6-19-57 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Farrelly | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--------------------------------------|--|
| NAME OF DECEASED (Print or Write) | | SEX (Male or Female) | | AGE (In Years, Months, and Days) | |
| DATE OF DEATH (Month, Day, and Year) | | PLACE OF DEATH (City, County, and State) | | TIME OF DEATH (Hour and Minute) | |
| CAUSE OF DEATH (State the cause of death in full) | | MANNER OF DEATH (Natural, Accidental, or Suicidal) | | SIGNATURE OF DECEASED (If known) | |
| SIGNATURE OF PHYSICIAN (If known) | | SIGNATURE OF CORONER (If known) | | SIGNATURE OF WITNESSES (If known) | |

BUREAU V. 2

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6482

CERTIFICATE OF DEATH

06445

212

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville, R.F.D. | | | | c. LENGTH OF STAY IN, b 2 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home | | | | d. STREET ADDRESS 4311 Argyle Terrace, N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Haddie Middle Smith Last Chiswell | | | | 4. DATE OF DEATH Month June Day 3 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 26-1885 | |
| 9. AGE (In years last birthday) yrs. 71 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | |
| 13. FATHER'S NAME Robert Smith | | | | 14. MOTHER'S MAIDEN NAME Katie Schwartz | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs Whitney Sweeney, 4311 Argyl Terrace, Washington | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 1954, to 3 June , 1957, that I last saw the deceased alive on 3 June , 1957, and that death occurred at 10 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edwin M. Smith | | | | ADDRESS (Street, city or town, state) DATE SIGNED RFD Boyd, Maryland 4 June 57 | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY Monocacy | | 22d. LOCATION (City, town, or county) (State) Beallsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton | | | | ADDRESS Barnesville, Md. | | 24a. REC'D BY REGISTRAR DATE 6/4/57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Charles W. Elgin | |

10

RECEIVED

6483

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06446

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 14 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital | | | | d. STREET ADDRESS 4426 Volta Place, N.W. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Bladen Middle Dulany Last CLAGGETT, Jr. | | | | 4. DATE OF DEATH Month June Day 5 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 4, 1939 | |
| 9. AGE (In years lost birthday) 17 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY Student | | 11. BIRTHPLACE (State or foreign country) Canal Zone | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Bladen Dulany CLAGGETT | | | | 14. MOTHER'S MAIDEN NAME Rhea A. ROBINSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Father, Bladen D. CLAGGETT (Same as #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor, basilar; type unknown 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 months | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 22 , 1957, to June 5 , 1957, that I last saw the deceased alive on June 5 , 1957, and that death occurred at 2:52 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-7-57 | | | | | | | |
| ACTUAL SIGNATURE Burt C. Johnson | | M.D. U.S. Naval Hospital, Bethesda, Md. 6-7-57 | | | | | |
| PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-10-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons | | ADDRESS Wash., D.C. | | 24a. REC'D BY REGISTRAR 6-6-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 06447 | |
|--|--|---|---|---|---|--|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In auto at Old Montg. Co. Home | | | | | d. STREET ADDRESS 601 Anderson Ave. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Julian Middle Keen Last Cochran | | | | | 4. DATE OF DEATH Month 6 Day 18 Year 57 | | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/14/12 | | 9. AGE (In years last birthday) 44 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Levi W. Cochran | | | | | 14. MOTHER'S MAIDEN NAME Sarah Lewis | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 578-07-0955 | | 17. INFORMANT Mrs. A.F. Beane- 129 S. Adams St. Rockville, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead in auto of his car | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 22b. DATE THEREOF 6/20/57 | | 22c. NAME OF CEMETERY OR CREMATORY Rockville Union Cem. | | | 22d. LOCATION (City, town, or county) (State) Rockville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR JUN 21 1957 | | 24b. REGISTRAR'S SIGNATURE Overman | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | | EXAMINER'S NAME (Type) Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 6/18/57 | | |

MEDICAL CERTIFICATION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-------------------------------|--|----------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| John Doe | | Male | | 45 | | June 15, 1957 | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| Boston, Mass. | | Boston, Mass. | | Heart Disease | | Natural | |
| Occupation | | Education | | Medical History | | Previous Illnesses | |
| Teacher | | High School | | Hypertension | | None | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Date of Examination | | Time of Examination | | Place of Examination | | Signature of Physician | |
| June 15, 1957 | | 10:00 AM | | Boston, Mass. | | [Signature] | |

BUREAU V. S.

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06448

6484

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. LENGTH OF STAY IN 1b x2 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | d. STREET ADDRESS 3609 Lawrence Ave | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3609 Lawrence Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) NORA First D. Middle COCHRAN Last | | 4. DATE OF DEATH June 24, Month June 24, Day 19 57 Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/4/1892 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Texas | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Joe Alexander Miller | | 14. MOTHER'S MAIDEN NAME Nellie Holt Glover | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-20-1916 | |
| 17. INFORMANT James L. Clark- Same as Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypostasis DUE TO (c) Cerebral Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs 7 days Many Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 522x Bad Patient for year | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August , 19 53 to June 24 , 19 57 , that I last saw the deceased alive on June 24 , 19 57 , and that death occurred at 10:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4413 Bradley Lane DATE SIGNED Bradley D. Hodgkins M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Bradley D. Hodgkins-4413 Bradley Lane, Chevy Chase, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/27/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR 6-27-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | |
|-----------------------|--|--------------------------------|--|
| NAME OF DECEASED | | AGE | |
| SEX | | RACE | |
| DATE OF DEATH | | PLACE OF DEATH | |
| CITY | | COUNTY | |
| STATE | | COUNTRY | |
| OCCUPATION | | CAUSE OF DEATH | |
| MANNER OF DEATH | | MEDICAL ATTENDANT | |
| SIGNATURE OF DECEASED | | SIGNATURE OF MEDICAL ATTENDANT | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | |

BUREAU V. S.

JUL 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6485

CERTIFICATE OF DEATH

Reg. Dist. No.

07581
216

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookdale xo</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden San.</u> | | d. STREET ADDRESS <u>4608 Overbrook Rd</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Frances</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 28, 1867</u> |
| 9. AGE (In years, lost birthday) <u>90</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Grant Mickum</u> | | 14. MOTHER'S MAIDEN NAME <u>Eliza Jane Parker</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>450.0</u> | |
| 17. INFORMANT <u>Mrs Paul H. Doerr</u> | | Address <u>4608 Overbrook Rd - Brookdale Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Acute</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, severe, generalised</u> DUE TO <u>Advanced senility</u> (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9:27</u> , 19 <u>56</u> , to <u>June 28, 1957</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>57</u> , and that death occurred at <u>9:28</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar St NW.</u> <u>6-28-57</u> PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>Wash. D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7-1-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivert Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J Lee & Sons 300 4th St N.E. Wash DC</u> | | 24a. REC'D BY REGISTRAR DATE <u>7-3-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Beanie M Thompson</u> | | | |

CERTIFICATE OF DEATH

Advanced senility
Arteriosclerosis, severe, generalized
Cerebral Thrombosis, Acute

3411 Indiana St. N.W.
BUREAU V. F. 8
1957

Stewart Glubb
Stewart Glubb

RECEIVED

6486

CERTIFICATE OF DEATH

06449
2/6

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | d. STREET ADDRESS 302 Adelaide Drive | |
| 3. NAME OF DECEASED (Type or print) First Ruby Middle Louise Last Conard | | 4. DATE OF DEATH Month June Day 22 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/19/87 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Loudon County, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Edward S. Benjamin | | 14. MOTHER'S MAIDEN NAME Mary Etta Hardy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Louise Towles Address 302 Adelaide Drive | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 444X | | | INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 4 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from SEPT. 1953 to JUNE 22 1957 that I last saw the deceased alive on JUNE 22, 1957 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leo M. Curtis M.D. 8218 Wisconsin Ave. | | DATE SIGNED 6/22/57 | |
| PHYSICIAN'S NAME (Type) Leo M. Curtis | | Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/25/57 | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | 22d. LOCATION (City, town, or county) (State) Washington 18, D. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington Funeral Home ADDRESS 3901 North Fairfax Drive, Arlington, Virginia | | 24a. REC'D BY REGISTRAR JUN 25 1957 | 24b. REGISTRAR'S SIGNATURE Bessie Thompson |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06450

6437

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp. Route 3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Floyd Middle Wallace Last CREGLOW | | 4. DATE OF DEATH Month June Day 4 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 17, 1908 |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months 2 Days 17 | IF UNDER 24 HRS. Hours 17 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Tec. | | 10b. KIND OF BUSINESS OR INDUSTRY Bureau of Stand. | |
| 11. BIRTHPLACE (State or foreign country) Minnesota | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME George B. Creglow | | 14. MOTHER'S MAIDEN NAME Mary Luther | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] yes WW 2 | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Dr. A. J. Janes | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Hepatic Flexure of Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 211X (b) DUE TO (c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Polypsis of Colon | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 11 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 3 , 19 57 , to June 4 , 19 57 , that I last saw the deceased alive on June 4 , 19 57 , and that death occurred at 7:45 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur F. Woodward M.D. | | DATE SIGNED Rockville - Md. 6/4/57 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | 22b. DATE THEREOF 6/7/57 | 22c. NAME OF CEMETERY OR CREMATORY Beneden Cemetery | 22d. LOCATION (City, town, or county) (State) Bridgeport, West Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | 24a. REC'D BY REGISTRAR 6/8/57 | |
| ADDRESS Bethesda, Maryland | | 24b. REGISTRAR'S SIGNATURE Esther B. Lawler | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED JAMES H. HARRIS | | 2. SEX Male | | 3. AGE 68 | |
| 4. PLACE OF BIRTH Baltimore, Md. | | 5. DATE OF BIRTH Jan. 1, 1889 | | 6. PLACE OF DEATH Baltimore, Md. | |
| 7. OCCUPATION Retired | | 8. CAUSE OF DEATH Heart Disease | | 9. MANNER OF DEATH Natural | |
| 10. SIGNATURE OF PHYSICIAN J. H. Harris | | 11. SIGNATURE OF FUNERAL HOME J. H. Harris | | 12. SIGNATURE OF WITNESSES J. H. Harris | |
| 13. DATE OF DEATH Jan. 1, 1957 | | 14. TIME OF DEATH 10:00 AM | | 15. PLACE OF INTERMENT Baltimore, Md. | |
| 16. NAME OF FUNERAL HOME J. H. Harris | | 17. NAME OF CEMETERY Baltimore, Md. | | 18. NAME OF MINISTER J. H. Harris | |
| 19. NAME OF CLERGYMAN J. H. Harris | | 20. NAME OF CHURCH Baltimore, Md. | | 21. NAME OF SPOUSE J. H. Harris | |
| 22. NAME OF CHILDREN J. H. Harris | | 23. NAME OF GRANDCHILDREN J. H. Harris | | 24. NAME OF OTHER RELATIVES J. H. Harris | |
| 25. NAME OF NEAREST RELATIVE J. H. Harris | | 26. NAME OF NEXT OF KIN J. H. Harris | | 27. NAME OF SURVIVORS J. H. Harris | |
| 28. NAME OF DECEASED'S MOTHER J. H. Harris | | 29. NAME OF DECEASED'S FATHER J. H. Harris | | 30. NAME OF DECEASED'S BROTHERS J. H. Harris | |
| 31. NAME OF DECEASED'S SISTERS J. H. Harris | | 32. NAME OF DECEASED'S UNCLE J. H. Harris | | 33. NAME OF DECEASED'S AUNT J. H. Harris | |
| 34. NAME OF DECEASED'S COUSINS J. H. Harris | | 35. NAME OF DECEASED'S Nephews J. H. Harris | | 36. NAME OF DECEASED'S Nieces J. H. Harris | |
| 37. NAME OF DECEASED'S GRANDNephews J. H. Harris | | 38. NAME OF DECEASED'S GRANDNieces J. H. Harris | | 39. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 40. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 41. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 42. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 43. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 44. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 45. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 46. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 47. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 48. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 49. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 50. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 51. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 52. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 53. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 54. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 55. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 56. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 57. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 58. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 59. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 60. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 61. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 62. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 63. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 64. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 65. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 66. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 67. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 68. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 69. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 70. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 71. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 72. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 73. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 74. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 75. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 76. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 77. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 78. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 79. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 80. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 81. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 82. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 83. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 84. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 85. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 86. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 87. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 88. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 89. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 90. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 91. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 92. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 93. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 94. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 95. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 96. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 97. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 98. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 99. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |
| 100. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 101. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | | 102. NAME OF DECEASED'S OTHER RELATIVES J. H. Harris | |

RECEIVED
JUN 14 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6488

CERTIFICATE OF DEATH

Reg. Dist. No.

02451

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Wisconsin Maryland b. COUNTY xxxxxxx | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 83 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital | | d. STREET ADDRESS 523 Park Avenue MOQ 938-B, U.S. Naval Air Station | |
| 3. NAME OF DECEASED (Type or print) First Suann Middle Marie Last CRONK | | 4. DATE OF DEATH Month June Day 3 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 12, 1957 |
| 9. AGE (In years last birthday) yrs. 2 Days 22 | | IF UNDER 1 YEAR Months 2 Days 22 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Robert Ray CRONK | | 14. MOTHER'S MAIDEN NAME Carole KAAS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Robert R. CRONK (Father) | | Address (Same as #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 mo 32 days | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 12 , 19 57 , to June 3 , 19 57 , that I last saw the deceased alive on June 3 , 19 57 , and that death occurred at 9:50P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George J. A. Magnant M.D. U.S. Naval Hospital, Bethesda, Md. 6-4-57 | | | |
| ACTUAL SIGNATURE George J. A. MAGNANT, LT, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-7-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | 24. REC'D BY REGISTRAR 6-5-57 | |
| 25. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

2050272XV5

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------------------|--|------------------------------|--|--------------------------------|--|----------------------------|--|-------------------------------|--|
| NAME OF DECEASED ROBERT A. ROBERTS | | AGE 63 years | | SEX Male | | RACE Caucasian | | DATE OF DEATH May 12, 1957 | |
| PLACE OF DEATH U.S. Naval Hospital | | CITY Baltimore | | COUNTY Baltimore | | STATE Maryland | | ZIP CODE 21201 | |
| OCCUPATION None | | EDUCATION None | | RELIGION None | | MARRIAGE None | | DATE OF BIRTH May 12, 1957 | |
| CAUSE OF DEATH None | | MANNER OF DEATH None | | IMMEDIATE CAUSE None | | UNDERLYING CAUSE None | | DATE OF DEATH May 12, 1957 | |
| SIGNATURE OF DECEASED None | | SIGNATURE OF WITNESS None | | SIGNATURE OF PHYSICIAN None | | SIGNATURE OF CLERK None | | DATE OF DEATH May 12, 1957 | |

BUREAU V. B.

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06452

6489

CERTIFICATE OF DEATH

Reg. Dist. No.

246

| | | | | | | | |
|--|-------------------------------|--|----------------------------------|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Crosser</u> Last | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-7-1874</u> | | 9. AGE (In years lost birthday) <u>82</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>26</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House of Representatives</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S. yes</u> | |
| 13. FATHER'S NAME <u>James Crosser</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Barbara Hogg</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Robert Crosser</u> Address <u>5518 Edgemoor Lane Bethesda 14 Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensation and congestive heart failure</u> 17 days DUE TO (b) <u>Arricular + ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>and myocarditis</u> 1 month | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u></u> Year <u></u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Dec</u> 1956, to <u>3 June</u> 1957, that I last saw the deceased alive on <u>2 June</u> 1957, and that death occurred at <u>3:50 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Herbert Martyn Jr</u> | | | | ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave</u> | | | |
| PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u> | | | | DATE SIGNED <u>3 June 57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u> | | 22b. DATE THEREOF <u>6/5/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cleveland, Ohio</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>Bessie M. Pumphrey</u> | |
| | | | | DATE <u>6/4/57</u> | | | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

Name of Deceased: **James Crocker**
 Sex: **Male**
 Race: **White**
 Date of Birth: **6-7-1874**
 Place of Birth: **Scotland**
 Usual Residence: **Robert Crocker, 2518 Edgewater Lane, Boston, Mass.**
 Cause of Death: **Heart Disease**
 Date of Death: **June 7, 1957**
 Place of Death: **Home**
 Signature of Physician: **James Crocker**
 Signature of Registrar: **Robert Crocker**
 Date of Registration: **June 14, 1957**

BUREAU V. R.

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6439

CERTIFICATE OF DEATH

Reg. Dist. No.

06453

3/73

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Mont | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, | | | | c. LENGTH OF STAY IN 1b 4 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6709 Gude Avenue | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park, Md. | | | |
| d. STREET ADDRESS 6709 Gude Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Weston LeRoy Middle Cryer Last Cryer | | | | 4. DATE OF DEATH Month June Day 3 Year 1957 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. B. DATE OF BIRTH 4/13/1899 | |
| 9. AGE (In years last birthday) 58 yrs. | | IF UNDER 1 YEAR Months 1 Days 3 Hours 19 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Eng. Safeway Store | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William Cryer | | 14. MOTHER'S MAIDEN NAME unobtainable -- Pittman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Betty Cryer 6709 Gude Ave., Takoma Pk, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Hypertension, old Cerebro-Vascular Accident 4 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO Hypertension, old Cerebro-Vascular Accident 4 yrs. (c) 420.1 | | | | | | INTERVAL BETWEEN ONSET AND DEATH Acute | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) 7 P.M. | | | | 20g. (County), | | 20h. (State) | |
| 21. I certify that I attended the deceased from April 26 , 19 53 , to June 3 , 19 57 , that I last saw the deceased alive on June 1 , 19 57 , and that death occurred at 7 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Ernest A. Sarao MD | | | | ADDRESS (Street, city or town, state) 7006 New Hampshire Ave | | | |
| DATE SIGNED 6/3/57 | | | | PHYSICIAN'S NAME (Type) Ernest A. Sarao | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) 6/7/57 | | 22b. DATE THEREOF 6/7/57 | | 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. | | | | ADDRESS Wash, D.C. | | 24a. REC'D BY REGISTRAR J. Wilson | |
| 24b. REGISTRAR'S SIGNATURE ADDY | | | | DATE JUN 6 1957 | | | |

RECEIVED

JUN 6 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06454

6490

CERTIFICATE OF DEATH

Reg. Dist. No.

218

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park</u> 16 x 12 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>4319 Van Buren Street</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Cumberland</u> Last <u>Cumberland</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>12th</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 6th, 1866</u> 90 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Thomas Cumberland</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Bannister</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>Mrs John Orspada Same d</u> | |
| 17. INFORMANT <u>Mrs John Orspada Same d</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Enteroschrotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>a. p.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 11, 1957</u> to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>7 P. M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James P. Kerr</u> | | ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>James P. Kerr</u> | | DATE SIGNED <u>6/12/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-15-1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u> | | 24. REC'D BY REGISTRAR <u>June 14 1957</u> | |
| ADDRESS <u>131-1118</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfreda G. Cook</u> | |

BUREAU V. E.

JUN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

6491

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06455

Reg. Dist. No.

| | | | |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seneca | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26 | |
| 3. NAME OF DECEASED (Type or print) George William CURTIS, Jr. | | d. STREET ADDRESS 508 Denham Road 1 | |
| 4. DATE OF DEATH Month June Day 15 Year 19 57 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 20, 1942 |
| 9. AGE (In years last birthday) 14 yrs. | | IF UNDER 1 YEAR Mo 0 Ds 25 | IF UNDER 24 HRS. Hours 25 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY Public School | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME George W. Curtis, Sr. | |
| 14. MOTHER'S MAIDEN NAME Mildred L. Harding | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Geo. W. Curtis, Sr. - Item # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in Potomac River | | 20c. TIME OF INJURY Month, Day, Year Hour 1:10 6/15/57 p. m. | |
| 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac river | |
| 20f. (City or town) Seneca | | (County) Montgomery (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED June 15, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 18, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Darnestown | 22d. LOCATION (City, town, or county) (State) Darnestown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 19 57 | |
| 24b. REGISTRAR'S SIGNATURE W. H. Smith | | | |

WESTLAND STATE DEPARTMENT OF HEALTH - EAST MORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|---|--|
| Name of Deceased | | George W. Williams | |
| Sex | | Male | |
| Race | | White | |
| Age | | 40.20, 1942 | |
| Date of Birth | | June 19, 1902 | |
| Place of Birth | | Rockville | |
| Occupation | | Student | |
| Education | | Public School | |
| Marital Status | | Married | |
| Spouse's Name | | Mary Jane Williams | |
| Spouse's Address | | 508 Linden Road | |
| Cause of Death | | Drowned while swimming in Potomac River | |
| Place of Death | | Potomac River | |
| Date of Death | | June 19, 1957 | |
| Time of Death | | 10:30 AM | |
| Signature of Medical Examiner | | George W. Williams, M.D. | |
| Signature of Coroner | | George W. Williams, M.D. | |

BUREAU V. 2

JUN 19 1957

RECEIVED

George W. Williams, M.D.
 June 19, 1957
 Potomac River, Potomac, Md.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 15, 16 Film 0217 7-12-57 et

Reg. Dist. No. 216

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN Tn | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7911 Kentbury Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BARENT HOILES De NIKE | | 4. DATE OF DEATH June 17 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 26, 1936 |
| 9. AGE (In years last birthday) 21 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Mass. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME J. Harold DeNike | | 14. MOTHER'S MAIDEN NAME Alice Hoiles | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Army No | | 16. SOCIAL SECURITY NO. 101-28-1738 | |
| 17. INFORMANT Father- Item # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic Hemorrhage DUE TO (b) Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Arm practically amputated at shoulder | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Threw self in front of approaching Freight Train | |
| 20c. TIME OF INJURY Month, Day, Year 6/17/ 19 57 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B & O R.R. | | 20f. (City or town) (County) (State) Bethesda, Montg. Co., Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Transit | | 22b. DATE THEREOF 6/18/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Montrose | | 22d. LOCATION (City, town, or county) (State) Bond County, Illinois | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumpfrey- Bethesda, Md. | | 24a. REC'D BY REGISTRAR 6-24-57 | |
| | | 24b. REGISTRAR'S SIGNATURE Beaumont Thompson | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

JUN 26 1957

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6133

CERTIFICATE OF DEATH

06457
2/7

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|-------------------------------------|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park - Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u> | | | | d. STREET ADDRESS <u>1212</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Dennis</u> Last <u>Dennis</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 9 1880</u> | 9. AGE (In years last birthday) <u>77</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Rutland, Iowa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Thiele</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sophia Blanker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>332X</u> | | 17. INFORMANT <u>Henry W. Stafford (son)</u> Address <u>5012 Mass Ave Wash. D.C. NW</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>443X</u> DUE TO <u>Cerebral Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>332X</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 weeks</u> <u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>June 8, 1957</u> , that I last saw the deceased alive on <u>June 8, 1957</u> , and that death occurred at <u>8:15</u> M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Boris Rabin</u> | | | | DATE SIGNED <u>1019 University Boulevard Silver Spring</u> | | | |
| PHYSICIAN'S NAME (Type) <u>BORIS RABIN M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B-11-57</u> | | 22b. DATE THEREOF <u>June 11-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Prompt Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. ...</u> ADDRESS <u>5406 M. Ave. D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>June 14 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u> | |

RECEIVED

JUN 14 1957

BUREAU V. S.

Donofrio, Enrico
8-11-57

8 days

Wash. D.C. 20535

Rutland, Iowa U.S.A.
Sept 9, 1980
Dennis June 8 57

Sharon Chronic Hospital
Close
Montgomery
Maryland
Bardley Park - Silver Spring
7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06458

6494

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|------------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNSYLVANIA</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MD.</u> | | c. LENGTH OF STAY IN 1b <u>9 DAYS</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - YORK SPRINGS</u> | | d. STREET ADDRESS <u>Rural Route 2 75x-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5903 JARVIS LANE</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>THEKESA CATHERINE DINSMORE</u> | | 4. DATE OF DEATH Month Day Year <u>JUNE 5 1957</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>AMER. IND.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT 1, 1888</u> |
| 9. AGE (In years lost birth day) <u>68</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME (FIRST NAME NOT KNOWN) <u>CONNOR</u> | | 14. MOTHER'S MAIDEN NAME (FIRST NAME NOT KNOWN) <u>FINNETTE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>011-18-7278</u> | |
| 17. INFORMANT - <u>SON</u> Address <u>BETHESDA, MD.</u> | | 18. <u>LESTER H. DINSMORE 5903 JARVIS LA.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CEREBRAL VASCULAR DISEASE</u> (c) <u>CONGESTIVE HEART FAILURE DUE TO RHEUMATIC HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>2 WEEKS</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X BRONCHOPNEUMONIA</u> | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from <u>MAY 27</u> , 19 <u>57</u> , to <u>JUNE 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 5</u> , 19 <u>57</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above. | |
| ADDRESS (Street, city or town, state) <u>9600 OLD GEORGETOWN RD. BETHESDA 14, MARYLAND</u> | | DATE SIGNED <u>5 June 1957</u> | |
| ACTUAL SIGNATURE <u>Joseph P. Connor</u> M.D. | | PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/10/1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Xavier</u> | | 22d. LOCATION (City, town, or county) (State) <u>Adams Co. (Gettysburg) Penna.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u> | | 24a. REC'D BY REGISTRAR <u>6-6-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6495

CERTIFICATE OF DEATH

Reg. Dist. No.

064594

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x 2 Silver Spring (Rural)</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairland Road</i> | | d. STREET ADDRESS <i>Fairland Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>M</i> Middle <i>P</i> Last <i>POOR</i> | | 4. DATE OF DEATH Month <i>6</i> - Day <i>16</i> Year <i>1957</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept 5, 1881</i> |
| 9. AGE (In years last birthday) <i>75</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>James Fitzpatrick</i> | | 14. MOTHER'S MAIDEN NAME <i>Batherine Cullen</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>725X</i> | |
| 17. INFORMANT <i>Catherine M. Rupphert</i> Address <i>Silver Spring Fairland Road</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i> DUE TO (b) <i>Arthritis</i> DUE TO (c) <i>Arthritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>725X</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>3/11</i> , 19 <i>56</i> , to <i>6/16</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/11</i> , 19 <i>57</i> , and that death occurred at <i>10:15</i> P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Frank Severs</i> | | ADDRESS (Street, city or town, state) DATE SIGNED <i>6/14/57</i> | |
| PHYSICIAN'S NAME (Type) | | M.D. <i>Sandy Sp...</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>6/20/57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i> | | 22d. LOCATION (City, town, or county) (State) <i>Arlington Va.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Severs Sons Co</i> ADDRESS <i>3605-14 St N W Wash D.C.</i> | | 24a. REC'D BY REGISTRAR <i>JUN 18 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Frances P...</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06460

6496

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wood Acres | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wood Acres | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5604 Gloster Road | | | | d. STREET ADDRESS 1 5604 Gloster Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Dwight David Doty | | | | 4. DATE OF DEATH Month Day Year June 5, 1957 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/10/1906 | |
| 9. AGE (In years lost birthday) yrs. 51 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | | 10b. KIND OF BUSINESS OR INDUSTRY Haley-Doty | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Thomas Doty | | | |
| 14. MOTHER'S MAIDEN NAME Rose Reid | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. no | | | | 17. INFORMANT Dorothy V. Doty - 5604 Gloster Road, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis 3 yrs (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Washington, D.C. | | | | 20g. (County) Montgomery | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from Aug. 1942 to June 5, 1957 , that I last saw the deceased alive on June 5, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James T. Burns | | | | ADDRESS (Street, city or town, state) 915-19th ST. N.W. Wash. D.C. | | | |
| DATE SIGNED 6/5/57 | | | | DATE SIGNED 6/5/57 | | | |
| PHYSICIAN'S NAME (Type) JAMES T. BURNS | | | | Wash. D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/8/57 | | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. | | | | ADDRESS 2901 14th St., N.W. | | 24a. REC'D BY REGISTRAR JUN 10 57 | |
| 24b. REGISTRAR'S SIGNATURE Paul Smith | | | | | | | |

CERTIFICATE OF DEATH

Page 10

| | | | | | |
|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Date of Birth | | Sex | |
| Thomas J. Wood | | 1910 | | Male | |
| Place of Birth | | Date of Death | | Time of Death | |
| Baltimore, Md. | | June 10, 1957 | | 10:30 AM | |
| Cause of Death | | Manner of Death | | Occupation | |
| Heart Disease | | Natural | | None | |
| Physician | | Hospital | | Burial Place | |
| J. H. Smith | | St. Mary's | | St. Mary's | |
| Signature of Physician | | Signature of Registrar | | Signature of Coroner | |
| [Signature] | | [Signature] | | [Signature] | |

BUREAU V. 3

JUN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6497

CERTIFICATE OF DEATH

Reg. Dist. No.

06462

214

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | |
| c. LENGTH OF STAY IN 1b 9 months | | d. STREET ADDRESS 409 Silver Spring Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Silver Spring Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) S. Isaac Elder | | 4. DATE OF DEATH June 15 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 10, 1869 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Knoxville, Iowa | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME S. Griffin Elder | | 14. MOTHER'S MAIDEN NAME Nancy Ellen Brady | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Florian J. Yeager | | Address 409 Silver Spring Avenue | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Resemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic renal disease DUE TO (c) 5 years | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5 June, 1957 , to 15 June, 1957 , that I last saw the deceased alive on 15 June, 1957 , and that death occurred at 11:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Seruch T. Kimble | | ADDRESS (Street, city or town, state) 929 Pershing Drive, Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type) Seruch T. Kimble | | DATE SIGNED 6/16/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 6/19/57 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 22d. LOCATION (City, town, or county) (State) St. Joseph, Missouri | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Werner E. Humphrey | | ADDRESS Silver Spring, Md. | |
| 24a. REC'D BY REGISTRAR 6/17/57 | | 24b. REGISTRAR'S SIGNATURE Hances | |

JUN 19 1957

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06463

6498

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | | | | | |
|---|-------------------|--|-------------------|---|-----------------|---|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Montgomery</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Montgomery</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN <u>Silver Spring</u> | | <u>1 year</u> | | TOWN <u>Silver Spring</u> | | <u>56</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3711 Randolph Rd.</u> | | | | STREET ADDRESS (If rural give location) <u>3711 Randolph Rd.</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| (Type or Print) <u>Oscar Maurice EISEN</u> | | | | OF DEATH: <u>6 15 1957</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>M</u> | <u>W</u> | <u>M</u> | <u>5-7-14</u> | <u>43</u> yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Contractor</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Roofing Contractor</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | |
| 13. FATHER'S NAME: <u>Louis N. Eisen</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Sarah Edelman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u> | | | | 16. SOCIAL SECURITY No. | | 17. INFORMANT & ADDRESS: <u>2312 Washington Ave. David T. Eisen, Chevy Chase, Md.</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> | | | | | | <u>30 mins.</u> | |
| DUE TO | | | | | | | |
| ANTECEDENT CAUSE (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>6/15/57</u> to <u>6/15/57</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:25 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Dr. Martin</u> | | ADDRESS <u>M. D. 2322 Blue Ridge Ave., Silver Spring, Md.</u> | | DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>6/16/1957</u> | | <u>NAT'L MEM. PARK</u> | | <u>FALLS CHURCH, VA.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>6-17-57</u> | | REGISTRAR'S SIGNATURE <u>Francis P. ...</u> | | 24. FUNERAL DIRECTOR | | ADDRESS <u>1600 4217-9-22</u> | |

RECEIVED

JUN 19 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6499

CERTIFICATE OF DEATH

Reg. Dist. No.

06464

216

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | |
| c. LENGTH OF STAY IN 1b 1 1/2 hours | | | | d. STREET ADDRESS 13202 Okinawa Avenue | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) EMMIE Grover Stevenson Ennis | | | | 4. DATE OF DEATH June 22 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/19/94 | |
| 9. AGE (In years last birthday) 62 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) Prince William County, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | | |
| 13. FATHER'S NAME George T. Ennis | | | | 14. MOTHER'S MAIDEN NAME Roxy Randall | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 229-34-3661 | | 17. INFORMANT Lena Pearson Address 13202 Okinawa Ave., Rockville | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hr. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-22 , 19 57 , to 6-22 , 19 57 , that I last saw the deceased alive on 6-22 , 19 57 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Jason Geiger M.D. | | | | ADDRESS (Street, city or town, state) 931 Pershing Dr., Silver Spring, Md. | | | |
| PHYSICIAN'S NAME (Type) JASON GEIGER | | | | DATE SIGNED 6-22-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/25/57 | | 22c. NAME OF CEMETERY OR CREMATORY Parklawn | | 22d. LOCATION (City, town, or county) (State) Rockville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR 6-24-57 | | 24b. REGISTRAR'S SIGNATURE Beanie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

75/5210 "I 24021

Robert A. Kennedy - President, 1961

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RECEIVED

JUN 26 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06465

6500

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY in 1b <u>2 1/2 weeks</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>800 Buckingham Drive</u> | | | | d. STREET ADDRESS <u>129 Philadelphia Avenue</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>VERNA S. EVANS</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 6 1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 5, 1877</u> | |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>P. Baldwin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ada Farabee</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Hazel Reng, 29 Philadelphia Ave T.P.M.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Right Hemisphere</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1:50 pm</u> , 19 <u>57</u> , to <u>6:50 am</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>57</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. B. Queen</u> M.D. <u>7112 Willow Ave</u> <u>6 June</u> PHYSICIAN'S NAME (Type) <u>A. B. QUEEN</u> <u>Takoma Park Md</u> <u>1957</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>June 6, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 294 Carroll Drive DC</u> | | | | 24a. RECEIVED BY REGISTRAR DATE <u>JUN 7 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | |

CERTIFICATE OF DEATH

1957 JUN 2

BUREAU V. S.

JUN 2 1957

RECEIVED

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED <i>James J. Smith</i> | | 2. SEX <i>Male</i> | |
| 3. AGE <i>45</i> | | 4. DATE OF BIRTH <i>1912</i> | |
| 5. PLACE OF BIRTH <i>St. Louis, Mo.</i> | | 6. OCCUPATION <i>Teacher</i> | |
| 7. MARITAL STATUS <i>Married</i> | | 8. EDUCATION <i>High School</i> | |
| 9. RELIGION <i>Catholic</i> | | 10. CAUSE OF DEATH <i>Heart Disease</i> | |
| 11. PLACE OF DEATH <i>Home</i> | | 12. TIME OF DEATH <i>10:30 PM</i> | |
| 13. SIGNATURE OF DECEASED <i>James J. Smith</i> | | 14. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 15. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Brown</i> | | 16. SIGNATURE OF CORONER <i>Mr. J. L. Green</i> | |
| 17. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 18. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 19. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 20. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 21. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 22. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 23. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 24. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 25. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 26. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 27. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 28. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 29. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 30. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 31. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 32. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 33. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 34. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 35. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 36. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 37. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 38. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 39. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 40. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 41. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 42. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 43. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 44. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 45. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 46. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 47. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 48. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 49. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 50. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 51. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 52. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 53. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 54. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 55. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 56. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 57. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 58. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 59. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 60. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 61. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 62. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 63. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 64. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 65. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 66. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 67. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 68. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 69. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 70. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 71. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 72. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 73. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 74. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 75. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 76. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 77. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 78. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 79. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 80. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 81. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 82. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 83. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 84. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 85. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 86. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 87. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 88. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 89. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 90. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 91. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 92. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 93. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 94. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 95. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 96. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 97. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 98. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |
| 99. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | | 100. SIGNATURE OF JURY <i>Mr. J. L. Green</i> | |

Reg. Dist. No.

06467
2/6

| | | | |
|--|-------------------------------|---|---------------------------------|
| 1. PLACE OF BIRTH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>5429 Connecticut Ave. NW. Wash DC</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash DC</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital, Bethesda, Md.</u> | | d. STREET ADDRESS <u>47X-3</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Katie</u> First <u>Fehér</u> Last | | 4. DATE OF DEATH <u>June</u> Month <u>22</u> Day <u>1957</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>3/17/82</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | |
| 17. INFORMANT <u>Attorney</u> Address <u>Room 808 Wash Press Bldg. Wash DC</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Interosclerotic Heart Disease</u> DUE TO (c) <u>5 YRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>587.0 Acute Pancreatitis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 1952 to <u>June 22</u> , 1957, that I last saw the deceased alive on <u>June 21</u> , 1957, and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert G. Angle</u> | | DATE SIGNED <u>5009 DEL RAY AVE, BETHESDA, MD.</u> | |
| PHYSICIAN'S NAME (Type) <u>ROBERT G ANGLE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6-26-1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u> | | 22d. LOCATION (City, town, or county) (State) <u>WEBSTER ST WASH DC</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co</u> | | ADDRESS <u>1400 Chapin St</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE JUN 25 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|-------------------------|--|------------------------|--|---------------------------|--|------------------------|--|-------------------|--|---------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1922 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | U.S.A. | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY OF MARRIAGE | | COUNTRY OF MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| MARRIED | | 1945 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | U.S.A. | | JUN 25 1968 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | |
| OCCUPATION | | DATE OF OCCUPATION | | PLACE OF OCCUPATION | | CITY OF OCCUPATION | | COUNTRY OF OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF EXAMINATION | |
| ATTORNEY | | 1960 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | U.S.A. | | HEART DISEASE | | NATURAL | | JUN 25 1968 | |
| EDUCATION | | DATE OF EDUCATION | | PLACE OF EDUCATION | | CITY OF EDUCATION | | COUNTRY OF EDUCATION | | SIGNATURE OF PHYSICIAN | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | |
| HIGH SCHOOL | | 1940 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | U.S.A. | | JAMES EARL RAY | | JUN 25 1968 | | MEMPHIS, TENN. | |
| RELIGION | | DATE OF RELIGION | | PLACE OF RELIGION | | CITY OF RELIGION | | COUNTRY OF RELIGION | | SIGNATURE OF CORONER | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | |
| METHODIST | | 1940 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | U.S.A. | | JAMES EARL RAY | | JUN 25 1968 | | MEMPHIS, TENN. | |
| FAMILY HISTORY | | DATE OF FAMILY HISTORY | | PLACE OF FAMILY HISTORY | | CITY OF FAMILY HISTORY | | COUNTRY OF FAMILY HISTORY | | SIGNATURE OF REGISTRAR | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | |
| FATHER: JAMES EARL RAY | | 1900 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | U.S.A. | | JAMES EARL RAY | | JUN 25 1968 | | MEMPHIS, TENN. | |
| MOTHER: JAMES EARL RAY | | 1900 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | | U.S.A. | | JAMES EARL RAY | | JUN 25 1968 | | MEMPHIS, TENN. | |

RECEIVED
JUN 25 1968
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06468

CERTIFICATE OF DEATH

Reg. Dist. No. 123

6440

| | | | |
|--|--|--|----------------------------------|
| 1. PLACE OF DEATH Montgomery | | 2. USUAL RESIDENCE (HOME) OF DECEASED D. C. | |
| COUNTY | MARYLAND | STATE | COUNTY |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN | LENGTH OF STAY (If this party) 30 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | Washington |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Santitarium Hosp | STREET ADDRESS (If rural give location) 425 Butternut N. W. | | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| (First) Bessie (Middle) Fenton (Last) | | (Month) June (Day) 1, (Year) 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH 8-1-70 |
| 9. AGE last birthday 86 yrs. | | IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov. Retiree | |
| 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME William H. Fenton | | 14. MOTHER'S MAIDEN NAME Cordelia Walker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS Hosp. Chart | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 175X IMMEDIATE CAUSE (A) Carcinoma of Ovaries, with Metastasis DUE TO to colonand to retrogentoneal lymph nodes DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) | | | several months |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 4, 1949, to June 1, 1957, that I last saw the deceased alive on May 31, 1957, and that death occurred at M. from the causes and on the date stated above. | | | |
| SIGNATURE J. Nelson | | DATE SIGNED June 2, 1957 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 24. REC'D BY REGISTRAR J. Nelson | |
| DATE JUN 6 1957 | | 25. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home | |
| 24. REGISTRAR'S SIGNATURE | | ADDRESS 4812 Ga. Ave. N. W. Wash. D. C. | |

CERTIFICATE OF DEATH

Page No. 1

1. Name of Deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of Birth: [illegible]

5. Place of Birth: [illegible]

6. Date of Death: [illegible]

7. Cause of Death: [illegible]

8. Place of Death: [illegible]

9. Signature of Physician: [illegible]

10. Signature of Registrar: [illegible]

11. Signature of Coroner: [illegible]

12. Signature of Medical Examiner: [illegible]

13. Signature of Health Officer: [illegible]

14. Signature of [illegible]: [illegible]

15. Signature of [illegible]: [illegible]

16. Signature of [illegible]: [illegible]

17. Signature of [illegible]: [illegible]

18. Signature of [illegible]: [illegible]

19. Signature of [illegible]: [illegible]

20. Signature of [illegible]: [illegible]

BUREAU V. S.

JUN 6 1957

RECEIVED

RECEIVED

6502

CERTIFICATE OF DEATH

Reg. Dist. No. 218

06469

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Montg MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN IB 4 Yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) June Pauline Filsinger | | 4. DATE OF DEATH June 13 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 14-1927 |
| 9. AGE (In years last birthday) 30 yrs. | | IF UNDER 1 YEAR Months 29 Days 29 Hours Min. | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician | | 10b. KIND OF BUSINESS OR INDUSTRY Beauty Salon | |
| 11. BIRTHPLACE (State or foreign country) Zihlman. Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Abram Windfield | | 14. MOTHER'S MAIDEN NAME Marion Downton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. George E Filsinger. Gaithersburg. Md. | |
| 17. INFORMANT George E Filsinger. Gaithersburg. Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asthma, Bronchial 241X DUE TO anti Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) anti DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 8 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year June 12 19 57 Hour o. ft. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 12 19 57 , to June 13 19 57 , that I last saw the deceased alive on June 12 19 57 , and that death occurred at 2:00 p. M. from the causes and on the date stated above. | | DATE SIGNED June 15-57 | |
| ACTUAL SIGNATURE Jack Schumacher | | ADDRESS (Street, city or town, state) 26 N. Summit Ave. 6-14-57 | |
| PHYSICIAN'S NAME (Type) Saundersbury, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-16-57 | 22c. NAME OF CEMETERY OR CREMATORY Eckhard | 22d. LOCATION (City, town, or county) (State) Eckhard Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Frostburg. Md | | 24a. REC'D BY REGISTRAR June 15-57 | |
| | | 24b. REGISTRAR'S SIGNATURE Abner L. Cooke | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 81 NOV

RECEIVED

6441

CERTIFICATE OF DEATH

06470

Reg. Dist. No.

223

| | | | | | | | |
|--|----------------------------|--|--------------------------------|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>39 minutes</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u> | | | | e. STREET ADDRESS <u>7209 Flower Avenue</u> | | | |
| 4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First <u>Baby Girl</u> Middle <u>Ford</u> Last <u>Ford</u> | | 4. DATE OF DEATH | | Month <u>6</u> Day <u>6</u> Year <u>1957</u> | |
| 5. SEX <u>girl</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/6/07</u> | 9. AGE (In years last birthday) yrs. <u>39</u> | IF UNDER 1 YEAR Months <u>39</u> Days <u>39</u> | IF UNDER 24 HRS. Hours <u>39</u> Min <u>39</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>Charles Theodore Ford</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mildred Jean Dentith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT <u>mother</u> | | Address <u>as above</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal hydrocephalus</u> <u>753.1</u> DUE TO <u>Fetal malformation of the Brainstem?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>756. Ascites - cirrhosis of liver</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>6/6</u> , 19 <u>57</u> , to <u>6/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/6/57</u> , 19 <u>57</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>D.A. St. Martin</u> | | | | M.D. <u>9820 Dameron Dr. Silver Spring Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>D.A. St. Martin</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>6-16-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hosp.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Takoma Park 12, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Farley</u> | | | | ADDRESS <u>Wash. San. & Hospital, Takoma Park</u> | | 24a. REC'D BY REGISTRAR <u>6/10/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075222XV2

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|----------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | |
| JAMES EARL RAY | | Male | | 35 | | White | | 1922 | | Memphis, Tennessee | |
| 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | | 10. DATE OF DEATH | | 11. PLACE OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| Attorney | | Suicide | | Suicide | | June 6, 1968 | | St. Louis, Missouri | | [Signature] | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF WITNESS | | 16. SIGNATURE OF WITNESS | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF WITNESS | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. 2

JUN 21 1968

RECEIVED

6503
CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 31 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Arturo Middle Vazquez Last Fourzan | | | | 4. DATE OF DEATH Month June Day 20 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 1, 1955 | |
| 9. AGE (In years last birthday) one yrs. | | 10. IF UNDER 1 YEAR Months 11 Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) Mexico | | 12. CITIZEN OF WHAT COUNTRY? Mexico ✓ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Mexico | |
| 13. FATHER'S NAME Oswaldo Fourzan | | | | 14. MOTHER'S MAIDEN NAME Theresa Vazquez | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S NAME AND ADDRESS The Medical Record The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency 204.4 DUE TO Pulmonary effusions; inflammations, Abd. Organomegaly Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemia DUE TO (c) Leukemia INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 weeks 7 mos | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5322 | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from May 20, 1957 to June 20, 1957 , that I last saw the deceased alive on June 20, 1957 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 6/20/57 | | | | | | | |
| ACTUAL SIGNATURE William J. Pieper M.D. | | | | The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) William J. Pieper, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6/21/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Panteon Jardin | | 22d. LOCATION (City, town, or county) (State) Mexico City, Mexico | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. | | | | 24a. REC'D BY REGISTRAR June 21 1957 | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SERVICIO EXTERIOR MEXICANO

No. -5- Derechos 50.00 M.N. \$15.4.00

CERTIFICO: que el Sr. William J. Pieper
Médico Cirujano del Hospital
Naval de Bethesda, Estado de Maryland,
es la autoridad competente para expedir
el certificado que antecede.

Washington, D. C. Junio 20 de 1957
P. O. del Embajador



R. Domínguez
Romeo Domínguez T.
Secretario

BUREAU U.S.

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6504

CERTIFICATE OF DEATH

06472
215

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital | | | | d. STREET ADDRESS 4215 12th Road South | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Laura Middle Virginia Last FOX | | | | 4. DATE OF DEATH Month June Day 18 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 8, 1909 | |
| 9. AGE (In years last birthday) 47 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Richard Henry YOUNG | | | | 14. MOTHER'S MAIDEN NAME Elizabeth WAGNER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Husband, Wilmer Leroy FOX (Same as #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerular Nephritis DUE TO (c) 20+ yrs. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from May 23 , 1957, to June 18 , 1957, that I last saw the deceased alive on June 18 , 1957, and that death occurred at 3:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-18-57 | | | | | | | |
| ACTUAL SIGNATURE T.S. DUNN, Jr. | | | | M.D. U.S. Naval Hospital, Bethesda, Md. 6-18-57 | | | |
| PHYSICIAN'S NAME (Type) T.S. DUNN, Jr., LT MC USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-21-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines, 2901 14th St., N.W., Washington, D.C. | | | | 24a. REC'D BY REGISTRAR 6-18-57 24b. REGISTRAR'S SIGNATURE Harry E. Parrelly | | | |

BUREAU

JUN 21 1957

RECEIVED

6595
CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|--|--|-------------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN TB 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredericksburg 838-3 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | d. STREET ADDRESS 1400 Kenmore Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Bradford Middle Daniel Last FRANZMAN | | | | 4. DATE OF DEATH Month June Day 9 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 2, 1957 | |
| 9. AGE (In years last birthday) yrs. 0 | | IF UNDER 1 YEAR Months 7 | | IF UNDER 24 HRS. Days 7 Hours 7 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME August Daniel FRANZMAN | | | | 14. MOTHER'S MAIDEN NAME Catherine STAIR | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - - - | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Father, August D. FRANZMAN (Same as #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) KERNIC TERUS 770.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - - - - - DUE TO (c) - - - - - | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Evansville, Indiana | | | | 20g. (County) Indiana | | | |
| 20h. (State) Indiana | | | | | | | |
| 21. I certify that I attended the deceased from June 7, 1957 to June 9, 1957 , that I last saw the deceased alive on June 9, 1957 , and that death occurred at 5:05 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Daniel Shuptar | | | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | | | |
| DATE SIGNED 6-10-57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Daniel SHUPTAR, LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-13-57 | | 22c. NAME OF CEMETERY OR CREMATORY Private Cemetery | | 22d. LOCATION (City, town, or county) (State) Evansville, Indiana | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | | | ADDRESS 7557 Wisc. Ave., Bethesda, Md. | | | |
| 24a. REC'D BY REGISTRAR 6-10-57 | | | | 24b. REGISTRAR'S SIGNATURE May E. Farrelly | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Figure 1

sample 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

528 5

1997) and the fact that the *in vitro* and *in vivo* results are in good agreement.

— 42 —

5264 • J. Neurosci., June 23, 2010 • 30(25):5259–5266

D. J. N.

1. *Phragmites* (Common Reed)

C62

BUREAU V. S.

JUN 11 1957

RECEIVED

1995-1996

12-31-01

1997

17-0-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6506 Item 7 Film G217 7-1-57 et
CERTIFICATE OF DEATH

06474

Reg. Dist. No. 214

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL HALL Sanitarium</u> | | d. STREET ADDRESS <u>1228 Eye St. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>S.</u> Last <u>GABLE</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 11-1878</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>IOWA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Peter E. Slaughter</u> | | 14. MOTHER'S MAIDEN NAME <u>MARGARET Hays</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>son</u> | | Address <u>Lewis M. Gable 1225 Park Ave..N.Y.,N.Y.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> <u>GENERALIZED ARTERIOSCLEROSIS</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>MAY 13</u> , 19 <u>56</u> , to <u>6-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-25</u> , 19 <u>57</u> , and that death occurred at <u>1:15A</u> M, from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <u>5206 Norway Dr.</u> | | DATE SIGNED <u>Chen Chao, M.D.</u> | |
| ACTUAL SIGNATURE <u>Benjamin F. Lander</u> | | M.D. | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. DATE OF BURIAL, CREMATION, REMOVAL (Specify) <u>6/26/57</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wagner Asso. Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Wagner, S. D.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 27 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u> | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------------|--|-------------|--|-----------|--|------------|--|---------------|--|----------------|--|-----------|--|-----------|--|-----------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JOHN W. BROWN | | 45 | | M | | W | | 1880 | | BALTIMORE | | MD | | USA | | USA | |
| MARRIAGE | | DATE | | PLACE | | CITY | | STATE | | COUNTRY | | CITY | | STATE | | COUNTRY | |
| MARRIED | | 1905 | | BALTIMORE | | MD | | USA | | USA | | BALTIMORE | | MD | | USA | |
| EDUCATION | | SCHOOL | | COLLEGE | | UNIVERSITY | | CITY | | STATE | | CITY | | STATE | | COUNTRY | |
| SCHOOL | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| OCCUPATION | | BUSINESS | | MANAGER | | CLERK | | CITY | | STATE | | CITY | | STATE | | COUNTRY | |
| BUSINESS | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| CAUSE OF DEATH | | HEART | | DISEASE | | CORONARY | | ARTERIES | | CITY | | STATE | | CITY | | COUNTRY | |
| HEART | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| DATE OF DEATH | | JUN 27 1957 | | CITY | | STATE | | CITY | | STATE | | CITY | | STATE | | COUNTRY | |
| JUN 27 1957 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| SIGNATURE OF PHYSICIAN | | J. W. BROWN | | M.D. | | CITY | | STATE | | CITY | | STATE | | CITY | | COUNTRY | |
| J. W. BROWN | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| SIGNATURE OF REGISTRAR | | J. W. BROWN | | M.D. | | CITY | | STATE | | CITY | | STATE | | CITY | | COUNTRY | |
| J. W. BROWN | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |

BUREAU V. S.

JUN 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06475

6507

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|------------------------------------|--|---|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | c. LENGTH OF STAY IN 1b 53 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 3612 Park Place, N. W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Sarah (No Middle Name) Gabriel | | | | 4. DATE OF DEATH Month June Day 9 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negroid | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 27, 1909 | | 9. AGE (In years lost birthday) yrs. 47 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Gabriel | | | | 14. MOTHER'S MAIDEN NAME Agnes Knox | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Not available | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstructive uropathy DUE TO (c) Carcinoma of the cervix uteri | | | | | | INTERVAL BETWEEN ONSET AND DEATH Three weeks at least 2 1/2 weeks One year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a. 9 p. m. Month, Day, Year 19 57 | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 17 , 19 57 , to June 9 , 19 57 , that I last saw the deceased alive on June 9 , 19 57 , and that death occurred at 6:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | |
| ACTUAL SIGNATURE Martin E. Liebling M.D. | | | DATE SIGNED 6/10/57 | | | | |
| PHYSICIAN'S NAME (Type) Martin E. Liebling, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 6/13/57 | | 22c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM | | 22d. LOCATION (City, town, or county) (State) MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Angela Funeral Home | | | | ADDRESS 389 R. 4 Avenue | | 24a. REC'D BY REGISTRAR JUN 12 1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06476
214

Reg. Dist. No.

6508

| | | | | | | | |
|---|--|---|---------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rear of Fred & Harry's Restaurant</u> | | | | d. STREET ADDRESS <u>1 104 Williamsburg Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>WILLIS</u> Last <u>GARNER</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1957</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/6/98</u> | |
| 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER and Bus Driver Instructor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>WILLIS H. GARNER</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>MELVIN WINDSTEAD</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | | |
| 16. SOCIAL SECURITY NO. <u>578-10-5567</u> | | 17. INFORMANT Address <u>Mrs. Ellen C. Wolfhope, 104 Williamsburg Drive Silver Spring, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>6/25/57</u> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/27/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>SILVER SPRING, MD.</u> | | | | 24a. REC'D BY REGISTRAR <u>6/30/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Francis C. Potter</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1875

BUREAU V. 2

3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06477

6509

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery 8101 Piney Branch Road Silver Spring MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. STREET ADDRESS 18101 Piney Branch Road | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Ivie Carole Middle Barr Last GRAEVES | | 4. DATE OF DEATH Month June Day 26 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec 28 1940 |
| 9. AGE (In years last birthday) 16 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (State or foreign country) District of Columbia |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Raymond B Graeves | |
| 14. MOTHER'S MAIDEN NAME Vivian Allie Barr McGinn | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Col Raymond B Graeves - 8101 Piney Br Silver Spring | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ependymoma 4th ventricle with metastasis to subarachnoid DUE TO (b) 193X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) to subarachnoid PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 1952 , 19 57 , to June 18 , 19 57 , that I last saw the deceased alive on 18 June , 19 57 , and that death occurred at 12:50A M, from the causes and on the date stated above. DATE SIGNED 6/26/57 ADDRESS (Street, city or town, state) Med Cert of Reg 4906, 20 Mar 44 | | | |
| ACTUAL SIGNATURE George J. Hayes M.D. | | DATE SIGNED 6/26/57 | |
| PHYSICIAN'S NAME (Type) George J Hayes | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 6/28/57 | 22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | 24a. REC'D BY REGISTRAR DATE 6/30/57 | 24b. REGISTRAR'S SIGNATURE Frances Potter |

BUREAU V. S.

1957 52

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06478

218

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore <i>Carmil</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN 1b 3 yrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Westminster <i>0627.2</i> | | d. STREET ADDRESS 3000 Bayview Road Eldersburg Rd. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH First Middle Last GRAF | | 4. DATE OF DEATH June Month 14 Day 1957 Year | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 12, 1871 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Sebastian Rockensuess | | 14. MOTHER'S MAIDEN NAME Mary Bartman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension (c) cardiovascular disease hypertrophied heart | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-11 , 19 56 , to 6-14 , 19 57 , that I last saw the deceased alive on June 12 , 19 57 , and that death occurred at 1:30 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Sarah Elizabeth Glover | | ADDRESS (Street, city or town, state) DATE SIGNED 4208 Anthony ST. Kensington Md 6-14-57 | |
| PHYSICIAN'S NAME (Type) Sarah Elizabeth Glover | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/17/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Com. | | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Dickner & Sons - Balt. | | 24a. REC'D BY REGISTRAR DATE 6/25/57 | |
| 24b. REGISTRAR'S SIGNATURE Alvinda E. Cook | | | |

CERTIFICATE OF DEATH

Elizabeth GRAF June 14 22

Infant - mother deceased
 1922 - 1923
 1924 - 1925

BUREAU V. 2

JUN 26 1957

RECEIVED

June 12 22
 1-309
 4-11
 25-6-24

Bo
 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07613

Reg. Dist. No. 214

6511

| | | | | | | | |
|---|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | | c. LENGTH OF STAY IN 1b <u>6 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington x2</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u> | | | | d. STREET ADDRESS <u>3000 McComas Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ned</u> Middle <u>Merrill</u> Last <u>Green</u> | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1957</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>5/10/1877</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Kan.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Nehemiah Green</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Sturtevant</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>W W I</u> | | 17. INFORMANT <u>San. Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> stating the underlying cause last. (b) <u> </u> (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/2/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Benbow's Son</u> | | | | 24a. REC'D BY REGISTRAR <u>1/5/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|-----------------------------------|--|------------------------------------|--|----------------------------------|--|-------------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. PLACE OF DEATH | |
| 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | | 13. SIGNATURE OF EXAMINER | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF CORONER | |
| 16. SIGNATURE OF PHYSICIAN | | 17. SIGNATURE OF NURSE | | 18. SIGNATURE OF CHAPLAIN | | 19. SIGNATURE OF MINISTER | | 20. SIGNATURE OF OTHER | |
| 21. SIGNATURE OF JURY | | 22. SIGNATURE OF JUDGE | | 23. SIGNATURE OF CLERK | | 24. SIGNATURE OF SHERIFF | | 25. SIGNATURE OF DEPUTY | |
| 26. SIGNATURE OF ATTORNEY | | 27. SIGNATURE OF DISTRICT ATTORNEY | | 28. SIGNATURE OF COUNTY ATTORNEY | | 29. SIGNATURE OF CITY ATTORNEY | | 30. SIGNATURE OF TOWN ATTORNEY | |
| 31. SIGNATURE OF VILLAGE ATTORNEY | | 32. SIGNATURE OF PARISH ATTORNEY | | 33. SIGNATURE OF CHURCH ATTORNEY | | 34. SIGNATURE OF SYNAGOGUE ATTORNEY | | 35. SIGNATURE OF MOSQUE ATTORNEY | |
| 36. SIGNATURE OF TEMPLE ATTORNEY | | 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | | 40. SIGNATURE OF OTHER | |

BUREAU V. 2

JUL 8 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6512

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06479

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 28 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Bethesda Chevy Chase | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | |
| d. STREET ADDRESS 1 3603 Dunlop Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Edith Middle Miller Last GREENLEE | | 4. DATE OF DEATH Month June Day 4 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-19-84 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James Miller | | 14. MOTHER'S MAIDEN NAME Elizabeth Farris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Daughter, Mrs. Elizabeth Oehmann (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Long Anasarea 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypoalbuminemia DUE TO (c) Cirrhosis, cause unknown | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 yrs. 15 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6 May , 19 57 , to 4 June , 19 57 , that I last saw the deceased alive on 3 June , 19 57 , and that death occurred at 4:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling M.D. U.S. Naval Hospital, Bethesda, Md. 6-4-57 | | | |
| ACTUAL SIGNATURE Charles U. SHILLING, MD (MC) USN | | PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-7-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | 24a. REC'D BY REGISTRAR 6-4-57 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Farrelly | | | |

BUREAU V. S.

JUN 6 1957

RECEIVED

6442

CERTIFICATE OF DEATH

Reg. Dist. No.

773

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Maryland</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Maryland</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i> | | | | d. STREET ADDRESS <i>12134 Views Mill Rd.</i> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Baby Boy</i> First Middle Last <i>Guthrie</i> | | | | 4. DATE OF DEATH Month <i>6</i> Day <i>10</i> Year <i>1957</i> | | | |
| 5. SEX <i>Boy</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>6-10-57</i> | |
| 9. AGE (In years last birthday) yrs. <i>52</i> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | | | | | | | |
| 13. FATHER'S NAME <i>Charles Marsh Guthrie</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Eleanor Stephanie Stechy</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <i>M. Roelke, R.N. Washington Sanitarium</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Erythema Nodosum Fekete</i> <i>770.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>June 10, 1957</i> to <i>June 10, 1957</i> , that I last saw the deceased alive on <i>June 10, 1957</i> , and that death occurred at <i>7:10 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>10620 Georgia Ave. Silver Spring, Md.</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Michael M. Dobridge</i> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>Michael M. Dobridge, M. D.</i> | | | | 10620 Georgia Avenue, Silver Spring, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>6-12-57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i> | | 22d. LOCATION (City, town, or county) (State) <i>WASH. D.C.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Timothy Haulon - 3831 - GA. Ave. N.W.</i> | | | | 24. REC'D BY REGISTRAR DATE <i>JUN 17 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>J. H. Nelson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6513

CERTIFICATE OF DEATH

06481

Reg. Dist. No.

217

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital | | | | d. STREET ADDRESS Clarksburg | | | |
| 3. NAME OF DECEASED (Type or print) First Austin Middle Warner Last Hammond | | | | 4. DATE OF DEATH Month June Day 20 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/13/98 | 9. AGE (In years last birthday) 59 yrs. | 10. IF UNDER 1 YEAR Months 1 Days 7 Hours Min. | | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Government Employee | | | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C. | | 11. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Otho Warner Hammond | | | | 14. MOTHER'S MAIDEN NAME Lula Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic cardiovascular disease 415X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from May 10 , 19 57 , to June 20 , 19 57 , that I last saw the deceased alive on June 20 , 19 57 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James P. Kerr | | | | ADDRESS (Street, city or town, state) Damascus, Md. | | | |
| PHYSICIAN'S NAME (Type) J. P. Kerr, M. D. | | | | DATE SIGNED 6/20/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/20/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Clarksburg Methodist | | 22d. LOCATION (City, town, or county) (State) Montgomery Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR JUN 24 1957 | | 24b. REGISTRAR'S SIGNATURE Gertrude Lawley | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6514

CERTIFICATE OF DEATH

06482

Reg. Dist. No. 218

| | | | |
|--|-------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Nicholas</u> Middle <u>Harding</u> Last <u>Harding</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5 1872</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>W.D.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Zechariah Harding</u> | | 14. MOTHER'S MAIDEN NAME <u>Ann Bozwell</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mr Joseph A Hall</u> | | Address <u>4105 Harrison St</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>2 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb.</u> , 1957, to <u>June 22</u> , 1957, that I last saw the deceased alive on <u>June 22</u> , 1957, and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D. | | ADDRESS (Street, city or town, state) <u>Germanstown, Md.</u> DATE SIGNED <u>6-22-57</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-25-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fourth Oak Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Garthman, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Garthman</u> | | ADDRESS <u>Garthman, Md.</u> | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <u>Abraham G. Cooke</u> | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6515
CERTIFICATE OF DEATH

Reg. Dist. No. 214

06483

| | | | |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2700 HARDY AVENUE | | d. STREET ADDRESS 2700 HARDY AVENUE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle EDNA Last HARDY | | 4. DATE OF DEATH Month JUNE Day 17 Year 57 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/4/76 |
| 9. AGE (In years last birthday) yrs. 80 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - Bureau of Engraving - U.S. Gov't. | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME J. FRANCIS HARDY | | 14. MOTHER'S MAIDEN NAME Mary E. Sheehy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. Beulah A. Clarke, 2700 Hardy Ave. | | Address Silver Spring, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 170x DUE TO Carcinoma breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) & metastases DUE TO abdomen (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 5 , 19 56 , to June 14 , 19 57 , that I last saw the deceased alive on June 17 , 19 57 , and that death occurred at 5:15 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Patrick Jameson M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 12020 Georgia 6/17/57 | |
| PHYSICIAN'S NAME (Type) PATRICK JAMESON | | Silver Spring Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/20/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY | | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey | | ADDRESS SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR DATE 6/20/57 | | 24b. REGISTRAR'S SIGNATURE Francis Potter | |

BUREAU V. S.

11N 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6516

CERTIFICATE OF DEATH

06484

Reg. Dist. No.

216

| | | | | | | | |
|---|-------------------------------|--|------------------------------------|---|-----------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | | c. LENGTH OF STAY IN 1b <u>4 DAYS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JONATHAN WATERS HASLUP</u> | | | | 4. DATE OF DEATH Month Day Year <u>JUNE 24 1957</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC-5-1892</u> | 9. AGE (In years last birthday) <u>64</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>GILBERT A. HASLUP</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ANNA TURNER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>SISTER</u> Address <u>MRS DOROTHY STACK HOUSE 3701 CONN.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Pulmonary Emphysema</u> DUE TO (c) <u>Ch. Myocardial Degeneration</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 yrs</u> <u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>6-12-57</u> , 19 <u>57</u> , to <u>6-24-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-23-57</u> , 19 <u>57</u> , and that death occurred at <u>12:05</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5412 Colo. Ave N.W. Washington D.C.</u> DATE SIGNED <u>6-24-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Andrew J. Betz</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Andrew J. Betz</u> Washington D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>6/26/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUN 25 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Rein Thompson</u> | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | |
| 4. DATE OF DEATH JUN 25 1968 | | 5. TIME OF DEATH 10:00 AM | | 6. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION | |
| 7. CAUSE OF DEATH Suicide | | 8. MANNER OF DEATH Homicide | | 9. DISEASE OR INJURY Gunshot wound | |
| 10. SIGNATURE OF PHYSICIAN [Signature] | | 11. SIGNATURE OF CORONER [Signature] | | 12. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 13. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 14. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 15. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 16. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 17. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 18. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 19. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 20. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 21. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 22. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 23. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 24. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 25. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 26. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 27. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 28. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 29. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 30. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 31. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 32. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 33. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 34. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 35. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 36. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 37. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 38. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 39. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 40. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 41. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 42. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 43. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 44. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 45. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 46. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 47. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 48. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 49. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 50. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 51. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 52. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 53. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 54. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 55. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 56. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 57. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 58. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 59. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 60. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 61. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 62. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 63. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 64. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 65. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 66. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 67. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 68. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 69. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 70. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 71. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 72. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 73. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 74. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 75. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 76. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 77. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 78. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 79. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 80. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 81. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 82. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 83. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 84. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 85. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 86. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 87. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 88. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 89. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 90. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 91. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 92. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 93. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 94. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 95. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 96. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 97. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 98. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 99. SIGNATURE OF DEATH CERTIFICATE [Signature] | |
| 100. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 101. SIGNATURE OF DEATH CERTIFICATE [Signature] | | 102. SIGNATURE OF DEATH CERTIFICATE [Signature] | |

RECEIVED
JUN 25 1968
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6517

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06485

Reg. Dist. No. 214

| | | | |
|---|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> 47x-3 ✓ | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>435 Northwest Drive</u> | | d. STREET ADDRESS <u>4801 Connecticut Avenue, N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert E. Heater</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 57</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/1/75</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John P. Heater</u> | | 14. MOTHER'S MAIDEN NAME <u>Matilda Wire</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Mrs. Evelyn S. Heater, 4801 Conn. Ave., N.W.</u> | | Address <u>Washington, D. C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound through skull</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted bullet wound</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>6:25</u> a. m. <u>6/16</u> 19 <u>57</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Office</u> | | 20f. (City or town) (County) (State) <u>Silver Spring, Montgomery, Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | DATE SIGNED <u>June 16, 1957</u> | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/18/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u> | | ADDRESS <u>SILVER SPRING, MD.</u> | |
| 24a. REC'D BY REGISTRAR <u>Francis Potter</u> | | 24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u> | |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-------------------------------|--|----------------------|--|------------------------|--|-----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| John P. [illegible] | | Male | | [illegible] | | [illegible] | |
| Residence | | Occupation | | Cause of Death | | Manner of Death | |
| [illegible] | | [illegible] | | [illegible] | | [illegible] | |
| Physician | | Hospital | | Coroner | | Medical Examiner | |
| [illegible] | | [illegible] | | [illegible] | | [illegible] | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Physician | | Signature of Hospital | |
| [illegible] | | [illegible] | | [illegible] | | [illegible] | |

BUREAU V. 3

JUN 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office only with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6518 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06486
Reg. Dist. No. 216

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>6 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4400 Glen Ridge Rd</u> | | | | d. STREET ADDRESS <u>4400 Glen Ridge Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lorraine</u> Middle <u>Chloe</u> Last <u>Heflin Jr</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1957</u> | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 8 1918</u> | | | |
| 9. AGE (In years last birthday) <u>38</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u> | | IF UNDER 24 HRS. Hours <u>2</u> Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Refrigeration Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Lorraine C. Heflin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Julius White</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>577-16-4607</u> | | 17. INFORMANT <u>Shirley Heflin</u> | | Address <u>Same as #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Ecdema of larynx</u> DUE TO (c) <u>Fulminating Bacterial Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>054X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>522X</u> <u>Edema Lungs</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>1 hour</u> <u>few hours</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosch MD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>6-3-57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/5/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>6/4/57</u> | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Pumphrey</u> | | | | | |

BUREAU V. S.

JUN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06487

6519

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED First Frances Middle Bell Last Henry | | | | 4. DATE OF DEATH Month June Day 9 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 23, 1889 | |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Admin. Assistant | | | | 10b. KIND OF BUSINESS OR INDUSTRY Dept. of Interior | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Joseph P. Fincham | | | | 14. MOTHER'S MAIDEN NAME Lillie Mitchell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) | | 17. INFORMANT Edith Henry Tufty | | Address Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Infarction 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple pulmonary emboli DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 153X Metastatic Carcinoma from Carcinoma of Colon | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. p. Month 19 Day 19 Year 1957 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from Dec. , 19 56 , to 6-9 , 19 57 , that I last saw the deceased alive on 6-9 , 19 57 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Russell M. Tilly, Jr. | | | | ADDRESS (Street, city or town, state) 4201 - Mass Ave. N.W. Wash. D.C. | | | |
| PHYSICIAN'S NAME (Type) Wash. D.C. | | | | DATE SIGNED 6-10-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6/12/57 | | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | | 22d. LOCATION (City, town, or county) (State) Woodlawn Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Clayton Funeral Home D.C. | | | | ADDRESS D.C. | | 24a. REC'D BY REGISTRAR DATE 6-18-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

MD-100 (REV. 1-78)

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BUREAU A.

JUN 19 1957

RECEIVED

6443

CERTIFICATE OF DEATH

064883

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 16152</u> ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Wash. San. & Hosp.</u> | | d. STREET ADDRESS <u>911 Ray Rd. Hyattsville</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Hannah Elizabeth Herder</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-22-81</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Don't employe</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Don't employe</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>William Hall</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Beach</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Chart</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> 19 <u>56</u> , to <u>June 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>57</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE <u>Ernest A. Sarao MD.</u> M.D. <u>7006 NEW HAMPSHIRE Ave</u> | | <u>6/18/57</u> | |
| PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO</u> | | <u>Takoma Park 12, MD.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>BURIAL</u> | <u>6/21/1957</u> | <u>CEDAR HILL CEM.</u> | <u>SUITLAND PR GEO CO, MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | |
| <u>W.W. Chambers Co. (Shelton Ave. Md.)</u> | | <u>JUN 24 1957</u> <u>W.W. Chambers</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6520

CERTIFICATE OF DEATH

06489

Reg. Dist. No.

212

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i> | | d. STREET ADDRESS <i>Rural</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Marshall</i> First <i>Hersberger</i> Middle <i>Hersberger</i> Last | | 4. DATE OF DEATH <i>June - 23 - 1957</i> Month <i>June</i> Day <i>23</i> Year <i>1957</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March - 22 - 1880</i> 9. AGE (In years last birthday) <i>77</i> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farming</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Prolesville, Montg Co, Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Aaron Bucher Hersberger</i> | | 14. MOTHER'S MAIDEN NAME <i>Edna Earle Hersberger</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Edna Earle Hersberger</i> Address <i>Prolesville, Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>23</i> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May - 23 - 1957</i> , to <i>June - 23 - 1957</i> , that I last saw the deceased alive on <i>June - 23 - 1957</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>William C. Miller</i> M.D. | | ADDRESS (Street, city or town, state) <i>7-Brooks Ave., Gaithersburg, Md.</i> | |
| DATE SIGNED <i>June - 23 - 1957</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | | 22b. DATE THEREOF <i>6/26/57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i> | | 22d. LOCATION (City, town, or county) (State) <i>Bethesda, Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Wilson</i> ADDRESS <i>Barnesville, Md</i> | | 24a. REC'D BY REGISTRAR DATE <i>6/25/57</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles W. Elgin</i> | |

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| Name of deceased | | Date of death | |
| William C. Miller | | June 23 - 1957 | |
| Age | | Date of birth | |
| 33 | | June 23 - 1924 | |
| Sex | | Place of birth | |
| Male | | Illinois | |
| Marital status | | Cause of death | |
| Married | | Heart disease | |
| Occupation | | Place of death | |
| Farmer | | Home | |
| Signature of physician | | Signature of registrar | |
| J. R. Brown | | J. R. Brown | |
| Date of death | | Date of registration | |
| June 23 - 1957 | | June 23 - 1957 | |
| Place of death | | Place of registration | |
| Home | | Home | |
| Signature of registrar | | Signature of registrar | |
| J. R. Brown | | J. R. Brown | |
| Date of registration | | Date of registration | |
| June 23 - 1957 | | June 23 - 1957 | |
| Place of registration | | Place of registration | |
| Home | | Home | |

BUREAU V. 3

JUN 27 1957

RECEIVED

6521

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 2335 California St NW | |
| 3. NAME OF DECEASED (Type or print) First EMELEEN Middle CARLISLE Last HILL | | 4. DATE OF DEATH Month June Day 24 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 27, 1876 |
| 9. AGE (In years last birthday) 81 yrs. | | 10. IF UNDER 1 YEAR Months 24 Days 19 Hours 57 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME David Carlisle | | 14. MOTHER'S MAIDEN NAME Emeline Howe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Marianna H. deBeers, 2335 Calif. St NW | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon & metastasis 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May , 1957, to June 24 , 1957, that I last saw the deceased alive on June 17 , 1957, and that death occurred at 3:10 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE A. D. Bonifant M.D. | | ADDRESS (Street, city or town, state) Sandy Spring Md DATE SIGNED 6/24/57 | |
| PHYSICIAN'S NAME (Type) A. D. BONIFANT | | Sandy Spring Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF 6/26/57 | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | 22d. LOCATION (City, town, or county) (State) Suitland Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Saunders | | 24a. REC'D BY REGISTRAR 6/26/57 | |
| 24b. REGISTRAR'S SIGNATURE Laurell Keaton | | ADDRESS 1756 Pennsylvania Ave NW, Washington, DC | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6522

CERTIFICATE OF DEATH

06491

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash.</u> <u>47X-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanatorium</u> | | | | d. STREET ADDRESS <u>2800 Quebec St. NW</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>PAUL</u> First <u>E.</u> Middle <u>HUE</u> Last <u>TTNER</u> | | | | 4. DATE OF DEATH <u>June 18 1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-3-1870</u> | |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov. Emp.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Huebner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Louise C. Hagen Daughter</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>A.S.C.U.D.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>years.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 6/18</u> , 19 <u>57</u> , to <u>6/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/18</u> , 19 <u>57</u> , and that death occurred at <u>5200</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Charles M. Weber</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>6/19/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>J. W. M. Lees</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lees</u> ADDRESS <u>300 - 4 ST NE</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>6-24-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED
JUN 26 1957
BUREAU V. S.

| | | | |
|--|--|--|--|
| NAME OF DECEASED <i>John J. Smith</i> | | SEX <i>Male</i> | |
| DATE OF BIRTH <i>1-1-1890</i> | | PLACE OF BIRTH <i>Worcester, Mass.</i> | |
| OCCUPATION <i>Engineer</i> | | CAUSE OF DEATH <i>Heart Disease</i> | |
| DATE OF DEATH <i>1-3-1950</i> | | PLACE OF DEATH <i>Home</i> | |
| TIME OF DEATH <i>10:30 AM</i> | | SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i> | |
| SIGNATURE OF REGISTRAR <i>[Signature]</i> | | OFFICIAL USE <i>[Stamp]</i> | |

6523

CERTIFICATE OF DEATH

06492

Reg. Dist. No. 214

| | | | |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 11 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg 85X-3 | |
| 3. NAME OF DECEASED (Type or print) First Larry Middle Eugene Last Hughes | | d. STREET ADDRESS 211 Rockwell Avenue | |
| 4. DATE OF DEATH Month June Day 25 Year 1957 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 24, 1942 |
| 9. AGE (In years lost birthday) 15 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stacey Hughes | | 14. MOTHER'S MAIDEN NAME Pearl Bivins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) venous DUE TO (c) acute leukemia | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) G | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 14, 1957 , to June 25, 1957 , that I last saw the deceased alive on 25 June, 1957 , and that death occurred at 12:15 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Thomas Waldmann | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/26/57 | |
| PHYSICIAN'S NAME (Type) Thomas Waldmann, M. D. | | National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/28/57 | 22c. NAME OF CEMETERY OR CREMATORY Rosedale | 22d. LOCATION (City, town, or county) (State) Martinsburg, W. Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 6-27-57 | |
| | | 24b. REGISTRAR'S SIGNATURE Debbie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Chief, Murphy-Belanda, A.C.
Bureau
10/20/57

RECEIVED

JUL 1 1957

BUREAU V. 3

6444

CERTIFICATE OF DEATH

Reg. Dist. No.

7/13

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY --- | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OAKHAVEN CONV. HOME. | | d. STREET ADDRESS West Clifton Terrace, N.W. | |
| | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | |
|---|----------------------------------|---|--|
| 3. NAME OF DECEASED (Type or print) Willis F. HURD | | 4. DATE OF DEATH Month June Day 17 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/26/69 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR Months 8 Days 17 Hours 17 Min. | 11. IF UNDER 24 HRS. Hours 17 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - exec. SOUTHERN RLWY | | 10b. KIND OF BUSINESS OR INDUSTRY Georgia | |
| 11. BIRTHPLACE (State or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Levi J. HURD | | 14. MOTHER'S MAIDEN NAME Letitia Johnson | |

| | | | |
|---|---|--|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 718-10-5943 | 17. INFORMANT Willis L. Hurd | Address 3716 Manor Road Chevy Chase, Md. |
|---|---|--|---|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) years. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH years. |
|---|--|---|

| | | |
|---|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|---|

| | | | |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| | |
|---|-------------------------------|
| 21. I certify that I attended the deceased from JULY 9, 1954 to JUNE 17, 1957 , that I last saw the deceased alive on JUNE 16, 1957 , and that death occurred at 10:54 A.M. , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE William F. Simpson, Jr. | DATE SIGNED 6/17/57 |
| PHYSICIAN'S NAME (Type) William F. Simpson, Jr. Washington, D.C. | |

| | | | |
|--|-------------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/19/57 | 22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
|--|-------------------------------------|--|--|

| | | | |
|--|---|---|--|
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. N. Hines Co. | ADDRESS 2901 14th St. N.W. Washington 9, D.C. | 24a. REC'D BY REGISTRAR J. Wilson | 24b. REGISTRAR'S SIGNATURE J. Wilson |
|--|---|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6445

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06494

Reg. Dist. No. 223

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park | |
| c. LENGTH OF STAY IN 1b Years | | d. STREET ADDRESS 6613 Alle gheny Ave | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6613 Alle gheny Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Isaac Middle Wilhelm Last ISAACSON | | 4. DATE OF DEATH 6/28/57 Month Day Year | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/18/1886 |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Same | |
| 11. BIRTHPLACE (State or foreign country) Sweeden | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Isaacson | | 14. MOTHER'S MAIDEN NAME Not Available | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 11ma S. Isaacon | |
| 17. INFORMANT Same as #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 6/28/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transit Burial | | 22b. DATE THEREOF 7/3/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cherry Cemetery | | 22d. LOCATION (City, town, or county) (State) Cherry, Minnesota | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters | | ADDRESS 254 Conroe St. N.W. Wash. D.C. | |
| 24a. REC'D BY REGISTRAR 7/1/57 | | DATE 7/1/57 | |
| 24b. REGISTRAR'S SIGNATURE J. William Dodd | | DATE | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|---------------|--|-----------------|--|----------------|--|-----------------|--|----------------|--|-----------------|--|-----------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Race | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | | Signature of Examiner | | Signature of Coroner | | Signature of Physician | |
| John Doe | | Male | | 45 | | White | | 1912 | | Maryland | | Baltimore | | Heart Disease | | Natural | | [Signature] | | [Signature] | | [Signature] | |
| Occupation | | Education | | Marital Status | | Religion | | Last Seen Alive | | Time of Death | | Place of Death | | Time of Death | | Place of Death | | Time of Death | | Place of Death | | Time of Death | |
| Teacher | | High School | | Married | | Catholic | | 1957 | | 1957 | | Home | | 1957 | | Home | | 1957 | | Home | | 1957 | |
| Date of Death | | Time of Death | | Place of Death | | Time of Death | | Place of Death | | Time of Death | | Place of Death | | Time of Death | | Place of Death | | Time of Death | | Place of Death | | Time of Death | |
| 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | |

BUREAU V. S.

JUL 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6524

CERTIFICATE OF DEATH

Reg. Dist. No.

06495

| | | | | | | | |
|--|---------------------------|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY MONTG MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DC b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | | | d. STREET ADDRESS 3460 39th St., N.W. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First CLARENCE Middle H. Last Jewell | | | | 4. DATE OF DEATH Month June Day 5 Year 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-20-94 | 9. AGE (In years last birthday) 62 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matre de | | | | 10b. KIND OF BUSINESS OR INDUSTRY Army Navy Club | | 11. BIRTHPLACE (State or foreign country) N.Y. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Judson Jewell | | | | 14. MOTHER'S MAIDEN NAME EMRETTA GRIZZIN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 17. INFORMANT Hospt Record. | | | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute coronary occlusion DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 6-2-57 , 19 57 , to 6-5-57 , 19 57 , that I last saw the deceased alive on 6-5-57 , 19 57 , and that death occurred at 4:10 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE C. Roger Kurtz M.D. | | | | ADDRESS (Street, city or town, state) 3701 Conn. Ave. N.W. DATE SIGNED 6-5-57 | | | |
| PHYSICIAN'S NAME (Type) C. Roger Kurtz | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 6/8/57 | | 22c. NAME OF CEMETERY OR CREMATORY National Mem. Park | | 22d. LOCATION (City, town, or county) (State) Fairfax Co., Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. | | | | ADDRESS Wash. D.C. | | 24a. REC'D BY REGISTRAR 6/10/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

BUREAU V.

JUN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6525

CERTIFICATE OF DEATH

Reg. Dist. No.

06496

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarkston 84 x - 3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center | | | | d. STREET ADDRESS Route #1, Box 1-F | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Helen | | First (No middle name) Middle Johnson | | 4. DATE OF DEATH June 3, 19 57 | | Month June Day 3 Year 19 57 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3 April 1911 | |
| 9. AGE (In years lost birthday) 46 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Health Nurse | | | | 10b. KIND OF BUSINESS OR INDUSTRY Government | | 11. BIRTHPLACE (State or foreign country) Idaho | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Paul W. Johnson | | | | 14. MOTHER'S MAIDEN NAME Lura Burdick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II | | | | 16. SOCIAL SECURITY NO. 574-10-2853 | | 17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from August 3, 19 56 , to June 3, 19 57 , that I last saw the deceased alive on June 3, 19 57 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED 6/4/57 | | | | | | | |
| ACTUAL SIGNATURE Arthur J. Garceau | | | | M.D. Arthur J. Garceau, M. D. | | | |
| PHYSICIAN'S NAME (Type) Arthur J. Garceau, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 22b. DATE THEREOF 6/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY Vineland, Cemetery | | 22d. LOCATION (City, town, or county) (State) Clarkston, Washington | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR 6-6-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

JUN 10 1957

RECEIVED

6526

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9412 Flower Ave.</u> | | d. STREET ADDRESS <u>19412 Flower Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Kathryn Tabitha Johnston</u> | | 4. DATE OF DEATH Month Day Year <u>June 29 1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>18 Sept 1906</u> |
| 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - Northwood & Blair High School</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PENNSYLVANIA</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Herbert A. Johnston</u> | | 14. MOTHER'S MAIDEN NAME <u>Bessie T. Schroger</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>199-20-7781</u> | |
| 17. INFORMANT <u>H. A. Johnston</u> | | Address <u>9412 Flower Ave. Silver Spring</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Sclerosis</u> DUE TO <u>1 yr</u> (c) <u>Generalized Arteriosclerosis</u> DUE TO <u>4-5 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> <u>Obesity & hypercholesterolemia</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 1954</u> to <u>29 June 1957</u> , that I last saw the deceased alive on <u>25 June 1957</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE <u>Merton L. White</u> M.D. <u>11134 George Ave. Md 29 June 57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>7/2/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u> | | ADDRESS <u>SILVER SPRING, MD.</u> | 24a. REC'D BY REGISTRAR DATE <u>6/30/57</u> |
| | | 24b. REGISTRAR'S SIGNATURE <u>Frances Totten</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

JUL 3 1957

RECEIVED

6527

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 33 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Lester Middle Earl Last Jones | | | | 4. DATE OF DEATH Month June Day 2 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 14 May 1892 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months 6 Days 1 Hours 5 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Decorator | | 10b. KIND OF BUSINESS OR INDUSTRY Unascertainable | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John H. Jones | | 14. MOTHER'S MAIDEN NAME Gertie Mertz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 578-26-2846 | | 17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive intrapulmonary hemorrhage and edema 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myelogenous leukemia DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days - |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from May 13, 19 57 , to June 2, 19 57 , that I last saw the deceased alive on June 2, 19 57 , and that death occurred at 12:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 6/2/57 | | | | | | | |
| ACTUAL SIGNATURE William J. Pieper | | | | M.D. The Clinical Center | | | |
| PHYSICIAN'S NAME (Type) William J. Pieper, M.D. | | | | National Institutes of Health | | | |
| Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JUNE 5-1957 | | 22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY | | 22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE BAST FUNERAL HOME | | | | ADDRESS BOONSBORO MD | | 24a. REC'D BY REGISTRAR June 5 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased: John Doe
 Date of Death: June 5, 1957
 Place of Death: Home
 Cause of Death: Heart Disease
 Age: 65
 Sex: Male
 Race: White
 Marital Status: Married
 Occupation: Teacher
 Signature of Physician: [Signature]
 Signature of Registrar: [Signature]
 Date of Registration: June 10, 1957
 Place of Registration: City of New York
 Registrar's Office: Health Department
 File Number: 100-30-1000

BUREAU V. 1

JUN 5 1957

RECEIVED

6528

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4918 Aurora Drive | | | | d. STREET ADDRESS 4918 Aurora Drive | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Cornelia Middle R. Last JOYCE | | | | 4. DATE OF DEATH Month June Day 5 Year 19 57 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/20/1892 | |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William C. Roberts | | | | 14. MOTHER'S MAIDEN NAME Jane A. Anderson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Francis J. Manning Address 4918 Aurora Drive Kensington, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Longestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 5/15/57 , 19____, to 6/5/57 , 19____, that I last saw the deceased alive on 6/5/57 , 19____, and that death occurred at 4 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Samuel Allen M.D. | | | | ADDRESS (Street, city or town, state) Kensington, Md. | | | |
| DATE SIGNED 6/5/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) SAMUEL ALLEN | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 6/10/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. | | | | ADDRESS -2901 14th St., N.W. | | 24a. REC'D BY REGISTRAR Frances Patten | |
| 24b. REGISTRAR'S SIGNATURE | | | | DATE JUN 10 1957 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

JUN 10 1957

RECEIVED

6529

CERTIFICATE OF DEATH

Reg. Dist. No. 212

| | | | | | | | |
|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Slidell | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) (Oliver) First Middle Last GARFIELD KEITH | | | | 4. DATE OF DEATH Month June Day 4 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 10, 1880 | 9. AGE (In years lost birthday) 76 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Nathen Keith | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. No | | | |
| 17. INFORMANT Mrs. Laura E. Keith | | | | Address Boyd's #2, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c) Secondary aneurysm | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year 6 months. 6 months. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic hypertrophy | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a. p. m. 19 | Month June | Day 15 | Year 19 53 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 15 , 19 53 , to 4 June , 19 57 , that I last saw the deceased alive on 3 June , 19 57 , and that death occurred at 9 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John G. Fawcett M.D. | | | | ADDRESS (Street, city or town, state) Dorhamville P.O. Boyd | | | |
| PHYSICIAN'S NAME (Type) John G. Fawcett M.D. | | | | DATE SIGNED 6/4/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 7, '57 | 22c. NAME OF CEMETERY OR CREMATORY Hyattstown Cem. | | 22d. LOCATION (City, town, or county) (State) Hyattstown, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber | | | | ADDRESS Saytonville Md. | | 24a. REC'D BY REGISTRAR DATE 6/7/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles W. Elgin | | | |

4

315

(1992:10)

BUREAU A. S.

JUN 10 1957

RECEIVED

| | | | | | | |
|------|----------------|----------------|---------------------|----------------|--------------|-----------|
| DATE | NAME OF VESSEL | PORT OF ORIGIN | PORT OF DESTINATION | TYPE OF VESSEL | REGISTRATION | STATUS |
| 1940 | U.S. Navy | San Francisco | San Francisco | U.S. Navy | U.S. Navy | U.S. Navy |

6530

CERTIFICATE OF DEATH

06501

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | d. STREET ADDRESS 3255 Patterson St., N.W. | |
| 3. NAME OF DECEASED (Type or print) Fannie First Middle Last Keller | | 4. DATE OF DEATH June 18 1957 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 16, 1876 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Maggie Thompson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Pauline Long Address N.W. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO (c) Hypertensive Cardio-Vascular-Renal Disease INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1956 to June 18, 1957 , that I last saw the deceased alive on June 17, 1957 , and that death occurred at 4:05 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stewart Clapp M.D. | | ADDRESS (Street, city or town, state) 3921 Ingoman St. N.W. Wash D.C. | |
| DATE SIGNED 6-18-57 | | | |
| PHYSICIAN'S NAME (Type) Stewart Clapp | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/20/57 | 22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington, D.C. | | 24a. REC'D BY REGISTRAR JUN 19 1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

| | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------|--|--------------------|--|-------------------|--|-------------------|--|--------------------|--|------------------------|--|---------------------------------|--|------------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Place of birth | | 6. Usual residence | | 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | | 10. Signature of registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1910 | | New York City | | 123 Main St | | Heart Disease | | Natural | | J. Smith | | A. Jones | |
| 11. Occupation | | 12. Education | | 13. Marital status | | 14. Date of death | | 15. Time of death | | 16. Place of death | | 17. Name of hospital | | 18. Name of attending physician | | 19. Name of medical examiner | | 20. Name of funeral home | |
| Teacher | | High School | | Married | | Jan 15, 1955 | | 10:00 AM | | Home | | St. Mary's | | Dr. Brown | | Dr. White | | Funeral Home | |
| 21. Name of informant | | 22. Relationship | | 23. Address | | 24. City | | 25. State | | 26. Zip | | 27. Date of completion | | 28. Signature of informant | | 29. Signature of registrar | | 30. Signature of physician | |
| Jane Doe | | Wife | | 123 Main St | | New York | | NY | | 10000 | | Jan 16, 1955 | | J. Doe | | A. Jones | | J. Smith | |

BUREAU V. E.

JUN 19 1957

RECEIVED

| 6531 | | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | 06502 | |
|---|-------------------------------|--|-----------------------------------|---|--|
| Item 11 Filed 9/21/7 7/3/57 | | CERTIFICATE OF DEATH | | Reg. Dist. No. 214 | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>95</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmer San. & Hospital</u> | | d. STREET ADDRESS <u>1 5506 Glenwood Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>B.</u> Last <u>Kelling</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-31-1879</u> | 9. AGE (In years last birthday) <u>78</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>19</u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. Teacher</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany Iowa</u> | |
| 13. FATHER'S NAME <u>O.L. Walweber</u> | | 14. MOTHER'S MAIDEN NAME <u>Sophia Klentz</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Marcia Weidenlopf</u> Address <u>5506 Glenwood Rd. Bethesda - Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro-Vascular Hemorrhage</u> DUE TO (c) <u>Generalized Arterio-Sclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 20</u> , 1953, to <u>June 19</u> , 1957, that I last saw the deceased alive on <u>June 19</u> , 1957, and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Merrill M. Cross</u> | | M.D. <u>5245 Resmer Ave. Bethesda, Md.</u> | | DATE SIGNED <u>6/19/57</u> | |
| PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS M.D.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u> | | 22b. DATE THEREOF <u>6/24/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u> | |
| | | | | 22d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert W. Humphrey</u> | | ADDRESS <u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 6-24-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|-------------------------|--|--------------------------|--|---------------|--|----------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | MALE | | 45 | | JAN 15 1912 | | NEW YORK | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JAN 15 1935 | | NEW YORK | | JUN 15 1957 | | NEW YORK | |
| OCCUPATION | | DATE OF OCCUPATION | | PLACE OF OCCUPATION | | DATE OF DEATH | | PLACE OF DEATH | |
| FARMER | | JAN 15 1935 | | NEW YORK | | JUN 15 1957 | | NEW YORK | |
| CAUSE OF DEATH | | DATE OF CAUSE OF DEATH | | PLACE OF CAUSE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | JAN 15 1935 | | NEW YORK | | JUN 15 1957 | | NEW YORK | |
| MANNER OF DEATH | | DATE OF MANNER OF DEATH | | PLACE OF MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | JAN 15 1935 | | NEW YORK | | JUN 15 1957 | | NEW YORK | |
| SIGNATURE OF PHYSICIAN | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JAN 15 1935 | | NEW YORK | | JUN 15 1957 | | NEW YORK | |
| SIGNATURE OF REGISTRAR | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JAN 15 1935 | | NEW YORK | | JUN 15 1957 | | NEW YORK | |

BUREAU V. H.

JUN 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8.9 Film 6217 7-12-57 et

CERTIFICATE OF DEATH

06593

Reg. Dist. No. 218

6532

| | | | | | | | |
|--|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Germantown, Md. | | | | c. LENGTH OF STAY IN 1b 2 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home | | | | e. STREET ADDRESS 12,408 Flack Street | | | |
| 3. NAME OF DECEASED (Type or print) Joseph F. Kelly | | | | 4. DATE OF DEATH June 23 19 57 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 12, 1885 | 9. AGE (In years last birthday) 72 1/2 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Elmira, N. Y. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Michael J. Kelly | | | | 14. MOTHER'S MAIDEN NAME Mary M. Hurley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Joseph M. Kelly Address Maryland 12408 Flack St., Silver Spring, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Cachexia | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months 1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY a. H. 19 p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from May 7, 1955 , to 23 June, 1957 , that I last saw the deceased alive on June 23, 1957 , and that death occurred at 100 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John G. Fawcett M.D. | | | | ADDRESS (Street, city or town, state) P.O. Box 1, Md. | | | |
| PHYSICIAN'S NAME (Type) JOHN G. FAWCETT M.D. | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL, or SPECIAL TRANS. & BURIAL | | 22b. DATE THEREOF 6/27/57 | | 22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY | | 22d. LOCATION (City, town, or county) (State) HORSEHEAD, NEW YORK | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey | | | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE June 26-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Abraham G. Cook | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|-----------------------|--|-------------------|--|
| NAME OF DECEASED | | DATE OF BIRTH | |
| JAMES H. HARRIS | | JANUARY 1, 1901 | |
| RESIDENCE | | OCCUPATION | |
| 1234 E. BALTIMORE ST. | | LABORER | |
| DATE OF DEATH | | PLACE OF DEATH | |
| JUNE 20, 1957 | | HOME | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| HEART DISEASE | | NATURAL CAUSE | |
| IMMEDIATE CAUSE | | UNDERLYING CAUSE | |
| CORONARY THROMBOSIS | | HEART DISEASE | |
| DATE OF REPORT | | REPORTED BY | |
| JUNE 28, 1957 | | JAMES H. HARRIS | |
| SIGNATURE OF REPORTER | | OFFICIAL USE | |
| JAMES H. HARRIS | | STATE OF MARYLAND | |

BUREAU V. S.

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6533

CERTIFICATE OF DEATH

Reg. Dist. No.

06504

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Florida | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pensacola 48 X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md. | | | | d. STREET ADDRESS 828 North K Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Christine (None) Kennedy | | | | 4. DATE OF DEATH Month June Day 22 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 17, 1929 | | 9. AGE (In years last birthday) 28 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unascertainable | | | | 14. MOTHER'S MAIDEN NAME Unascertainable | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic DUE TO (c) adenocarcinoma of the lung | | | | | | INTERVAL BETWEEN ONSET AND DEATH 17R | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from March 27 , 19 57 , to June 22 , 19 57 , that I last saw the deceased alive on June 22 , 19 57 , and that death occurred at 7:35A AM, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE Gurston Goldin M.D. | | | | The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) GURSTON GOLDIN, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 6.24-57 | | Pensacola | | FLA | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fraziers Funeral Home 389 | | | | 24. REC'D BY REGISTRAR DATE 6/22/57 | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>1. Name of deceased: <i>John Doe</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of birth: <i>Jan 1, 1900</i></p> | | <p>4. Age: <i>57 years</i></p> | |
| <p>5. Place of birth: <i>St. Louis, Mo.</i></p> | | <p>6. Usual residence: <i>1234 Main St., Baltimore, Md.</i></p> | |
| <p>7. Date of death: <i>June 27, 1957</i></p> | | <p>8. Time of death: <i>10:30 AM</i></p> | |
| <p>9. Cause of death: <i>Heart disease</i></p> | | <p>10. Manner of death: <i>Natural</i></p> | |
| <p>11. Physician: <i>Dr. J. H. Smith</i></p> | | <p>12. Hospital: <i>St. Agnes Hospital</i></p> | |
| <p>13. Burial place: <i>Greenwood Cemetery</i></p> | | <p>14. Burial date: <i>July 1, 1957</i></p> | |
| <p>15. Signature of physician: <i>J. H. Smith</i></p> | | <p>16. Signature of registrar: <i>John Doe</i></p> | |
| <p>17. Date of registration: <i>July 1, 1957</i></p> | | <p>18. Office of registration: <i>Baltimore, Md.</i></p> | |

BUREAU V. S.

JUN 27 1957

RECEIVED

Handwritten notes and signatures at the bottom of the form.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6446

CERTIFICATE OF DEATH

06505

Reg. Dist. No. 223

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <i>DC</i> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN <i>41 Days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47X-3</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hosp.</i> | | | | d. STREET ADDRESS <i>5012 Arkansas Ave. NW</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>John</i> Last <i>Kessler</i> | | | | 4. DATE OF DEATH Month <i>6</i> Day <i>15</i> Year <i>1957</i> | | | |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>3-29-92</i> | |
| 9. AGE (In years last birthday) <i>65 yrs.</i> | | IF UNDER 1 YEAR Months <i>6</i> Days <i>15</i> Hours <i>19</i> Min. | | 11. BIRTH PLACE (State or foreign country) <i>DC</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Govt. Employee Bur. of Eng.</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>DC</i> | | | |
| 13. FATHER'S NAME <i>Andrew Kessler</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Emilie Fender</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT <i>Chart</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive heart disease</i> DUE TO (c) <i>Essential hypertension</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>5 yrs</i> <i>28 yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Recent cerebral thromboses</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <i>19</i> Month <i>6</i> Day <i>15</i> Year <i>1957</i> a. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <i>Washington</i> | | | | 20g. (County) <i>DC</i> | | 20h. (State) <i>DC</i> | |
| 21. I certify that I attended the deceased from <i>5-4</i> 19 <i>57</i> to <i>6-15</i> 19 <i>57</i> , that I last saw the deceased alive on <i>6-15</i> 19 <i>57</i> , and that death occurred at <i>11:20 A.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Samuel M. Bageant</i> | | | | ADDRESS (Street, city or town, state) <i>Washington DC</i> | | | |
| PHYSICIAN'S NAME (Type) <i>SAMUEL M. BAGEANT</i> | | | | DATE SIGNED <i>6/15/57</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>6-18-57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill</i> | | 22d. LOCATION (City, town, or county) <i>Washington DC</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Beal</i> | | | | ADDRESS <i>4812 90. Ave NW.</i> | | 24a. REC'D BY REGISTRAR <i>J. Nelson</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>J. Nelson</i> | | DATE <i>JUN 20 1957</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6534

CERTIFICATE OF DEATH

Reg. Dist. No.

06506
216

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN 1b <u>11 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE X2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN HOSPITAL</u> | | | | d. STREET ADDRESS <u>7100 MEADOW LANE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>L</u> Last <u>KETCHAM</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1957</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 23-1910</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>EDWARD LUCAS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>EDITH GROVE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>A.C. KETCHAM</u> | | Address <u>7100 MEADOW LANE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 22, 1957</u> , to <u>June 1, 1957</u> , that I last saw the deceased alive on <u>May 31, 1957</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3927 Longmeadow St. 20013</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/3/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>6/4/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u> | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------------|--|-------------------|--|----------------------|--|-------------------|--|-----------------------|--|---------------------|--|-----------------------|--|--------------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | 65 | | M | | W | | JAN 15 1892 | | BALTIMORE | | MD | | MD | | USA | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY OF MARRIAGE | | STATE OF MARRIAGE | | COUNTRY OF MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| MARRIED | | JAN 15 1915 | | BALTIMORE | | MD | | MD | | USA | | JUN 10 1957 | | BALTIMORE | | MD | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | POLITICAL PARTY | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | |
| HEART DISEASE | | NATURAL | | LABORER | | HIGH SCHOOL | | METHODIST | | DEMOCRAT | | JUN 12 1957 | | BALTIMORE | | MD | |
| SIGNATURE OF PHYSICIAN | | DATE OF SIGNATURE | | SIGNATURE OF WITNESS | | DATE OF SIGNATURE | | SIGNATURE OF DECEASED | | DATE OF SIGNATURE | | SIGNATURE OF DECEASED | | DATE OF SIGNATURE | | SIGNATURE OF DECEASED | |
| JAMES H. HARRIS | | JUN 10 1957 | | JAMES H. HARRIS | | JUN 10 1957 | | JAMES H. HARRIS | | JUN 10 1957 | | JAMES H. HARRIS | | JUN 10 1957 | | JAMES H. HARRIS | |

BUREAU V. S.

JUN 7 1957

RECEIVED

MEDICAL CERTIFICATION

Charles W. Killy
Male White
Sept 16 1884 25
Calverton Va.
Josephine Duggan
Josephine Dixon Killy and
Barnard Killy
Brooks Grove Foundation
Grand Killy 22 days
Albany Killy

May 13 1957
BUREAU V. 2

JUN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6447

CERTIFICATE OF DEATH

06508

Reg. Dist. No. 223

| | | | | | |
|--|---------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 GRANT AVE | | | d. STREET ADDRESS 12 GRANT AVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE C. KING | | | 4. DATE OF DEATH Month Day Year JUNE 23, 1957 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC 3, 1893 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. SGT USGVT | | | 10b. KIND OF BUSINESS OR INDUSTRY USGVT. | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME JAMES R. KING | | | 14. MOTHER'S MAIDEN NAME ANNIE E. WALKER | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address MRS. OLIVE T. DUNN, 12 GRANT AVE. T.P. MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4.20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) 16 years | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 min - |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from June , 19 55 , to June , 19 57 ; that I last saw the deceased alive on June 11 , 19 57 , and that death occurred at 10:20 P.M. , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE James R. Coleman MD | | ADDRESS (Street, city or town, state) 113 Carroll St NW Wash. DC | | | |
| DATE SIGNED 6/23/57 | | | | | |
| PHYSICIAN'S NAME (Type) JAMES R. COLEMAN | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JUNE 26, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEM. | |
| 22d. LOCATION (City, town, or county) FORT GLEN, MONTGOMERY CO. MD | | (State) MD | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard J. Staley | | ADDRESS 254 Carroll St NW DC | | 24a. REC'D BY REGISTRAR 6/25/57 | |
| 24b. REGISTRAR'S SIGNATURE J. H. Johnson | | | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

W. H. KATHARINE
 12 Grant Ave
 LIFE
 11.11

12 Grant Ave
 12 Grant Ave
 12 Grant Ave

12 Grant Ave
 12 Grant Ave
 12 Grant Ave

RECEIVED
 JUN 26 1957
 BUREAU Y. E.
 12 Grant Ave
 12 Grant Ave
 12 Grant Ave

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6448

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06509
✓ 73

Reg. Dist. No.

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakoma Park c. LENGTH OF STAY IN lb 10 Min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. and Hosp. | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY P. G. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park 16 x 22 d. STREET ADDRESS 1355 Langley Way Apt. 101 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Florence Ann Koval | | | 4. DATE OF DEATH June 17/1957 | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 2/20/28 | | 9. AGE (In years last birthday) 29 yrs. | | IF UNDER 1 YEAR: Months 17 Days 19 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) SOUTH DAKOTA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME BERNARD BERNARD CLANCY | | 14. MOTHER'S MAIDEN NAME MARIE Quilty | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arsenic Poisoning IMMEDIATE CAUSE (a) 971.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO — (c) — | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. — | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Taken a quantity of Acme Weed Killer containing 42.5% arsenic | | | |
| 20c. TIME OF INJURY Month, Day, Year 5:00 p. m. 6/17/57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | |
| 20f. (City or town) Langley Pk. | | 20g. (County) P.G. | | 20h. (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 6/17/57 | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/21/57 | | 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL | |
| 22d. LOCATION (City, town, or county) ARLINGTON, VA. | | 22e. (State) VA. | | 22f. REC'D BY REGISTRAR J. Nelson Duddy | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. ALTAVULL | | ADDRESS 3619-14th St N.W. | | 24. REGISTRAR'S SIGNATURE J. Nelson Duddy | |

WASHDC

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---------------------------------------|--|
| NAME OF DECEASED [Faint text] | | SEX [Faint text] | |
| AGE [Faint text] | | DATE OF BIRTH [Faint text] | |
| OCCUPATION [Faint text] | | PLACE OF BIRTH [Faint text] | |
| MARITAL STATUS [Faint text] | | DATE OF DEATH [Faint text] | |
| CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | |
| SIGNATURE OF MEDICAL EXAMINER [Faint text] | | SIGNATURE OF DECEASED [Faint text] | |
| SIGNATURE OF WITNESS [Faint text] | | SIGNATURE OF DECEASED [Faint text] | |

BUREAU V. 5

JUN 19 1957

RECEIVED

6449

Item 1 Film 217 6-24-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|---|---------------------------|--|---------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, MD.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, MD.</u> | | | |
| c. LENGTH OF STAY IN 1b <u>16 hrs</u> | | | | d. STREET ADDRESS <u>923 Gabel Court</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>SUBAR</u> Middle <u>Lynn</u> Last <u>Kuehling</u> | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/14/56</u> | | 9. AGE (In years last birthday) yrs. <u>16</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>25</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Robt. Edward Kuehling</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Chase</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u></u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - meningococci -</u> <u>751X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/14/57</u> , 19 <u>57</u> , to <u>6/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/14/57</u> , 19 <u>57</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2322 Blue Ridge Ave.</u> DATE SIGNED <u></u> | | | | | | | |
| ACTUAL SIGNATURE <u>David St. Martin</u> | | | | M.D. <u>2322 Blue Ridge Ave.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>David St. Martin</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/17/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u> | | | | 24a. REC'D BY REGISTRAR <u>6/17/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Rott</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075221XV2

BUREAU V. S.

JUN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6536

CERTIFICATE OF DEATH

06511

Reg. Dist. No.

| | | | | | | | |
|---|---|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillandale Md | | | | c. LENGTH OF STAY IN 1b 14 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1732 Overlook Drive | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First James Middle Winfield Last Lanham | | | | 4. DATE OF DEATH Month June Day 5 Year 19 57 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 17, 1859 | 9. AGE (In years last birthday) 97 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Collington Md | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Stephen Lanham | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Henry | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Alme L Fisher Address 1732 Overlook Drive Hillandale, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Senility. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 1 1/2 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 572.1 Diverticulosis of Colon. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from April 1, 1951 , to June 5, 1957 , that I last saw the deceased alive on April 15, 1957 , and that death occurred at 11:00 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John R. Egan | | | | ADDRESS (Street, city or town, state) DATE SIGNED 1801 Eye St N.W. - Washington, D.C. | | | |
| PHYSICIAN'S NAME (Type) John R. Egan M.D. | | | | 1801 Eye St N.W. - Washington, D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 8, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md. | | | | 24a. REC'D BY REGISTRAR JUN 10 1957 | | 24b. REGISTRAR'S SIGNATURE J. Sedricks | |

CERTIFICATE OF DEATH

REG. DIV. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED <i>John J. Jones</i> | | 2. SEX <i>Male</i> | |
| 3. AGE <i>45</i> | | 4. DATE OF BIRTH <i>Jan 15 1900</i> | |
| 5. PLACE OF BIRTH <i>St. Louis, Mo.</i> | | 6. OCCUPATION <i>Engineer</i> | |
| 7. MARITAL STATUS <i>Married</i> | | 8. NAME OF SPOUSE <i>John J. Jones</i> | |
| 9. CAUSE OF DEATH <i>Heart Disease</i> | | 10. PLACE OF DEATH <i>Home</i> | |
| 11. TIME OF DEATH <i>10:30 AM</i> | | 12. SIGNATURE OF PHYSICIAN <i>John J. Jones</i> | |
| 13. SIGNATURE OF REGISTRAR <i>John J. Jones</i> | | 14. SIGNATURE OF WITNESSES <i>John J. Jones</i> | |
| 15. SIGNATURE OF DECEASED <i>John J. Jones</i> | | 16. SIGNATURE OF NEXT OF KIN <i>John J. Jones</i> | |
| 17. SIGNATURE OF BURIAL OFFICER <i>John J. Jones</i> | | 18. SIGNATURE OF CHURCH OFFICER <i>John J. Jones</i> | |
| 19. SIGNATURE OF MINISTER <i>John J. Jones</i> | | 20. SIGNATURE OF CLERGYMAN <i>John J. Jones</i> | |
| 21. SIGNATURE OF RABBI <i>John J. Jones</i> | | 22. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 23. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 24. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 25. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 26. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
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| 63. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 64. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 65. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 66. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
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| 69. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 70. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 71. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 72. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
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| 79. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 80. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 81. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 82. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 83. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 84. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 85. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 86. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 87. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 88. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 89. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 90. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 91. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 92. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 93. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 94. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 95. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 96. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 97. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 98. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |
| 99. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | | 100. SIGNATURE OF OTHER OFFICIAL <i>John J. Jones</i> | |

BUREAU V. 2

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06512

6537

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>16 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | | d. STREET ADDRESS <u>1508 North Kentucky Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Larsh</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19-57</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 26, 1917</u> | |
| 9. AGE (In years last birthday) <u>40</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Key Punch Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>John Manning</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Bessie Jones</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive debilitation</u> <u>172x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Disease</u> (c) <u>Carcinoma of Endometrium</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u> <u>20 mo.</u> <u>?</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>June 5, 1957</u> , to <u>June 21, 1957</u> , that I last saw the deceased alive on <u>June 21, 1957</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Clarence S. Weldon</u> | | | | ADDRESS (Street, city or town, state) <u>The Clinical Center National Institutes of Health Bethesda 14, Maryland</u> | | | |
| DATE SIGNED <u>6/21/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Clarence S. Weldon, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>June 25, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. [unclear]</u> | | | | ADDRESS <u>2847 Wilson Blvd., Arlington</u> | | 24a. REC'D BY REGISTRAR <u>6-24-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | | | | | | |

BUREAU 7

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6538

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06513

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 25 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | d. STREET ADDRESS 4634 Taney Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Aubrey Middle Travis Last LEAVELL | | | | 4. DATE OF DEATH Month June Day 1 Year 19 57 | | | |
| 5. SEX M | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 2, 1893 | |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Bowman B. LEAVELL | | | | 14. MOTHER'S MAIDEN NAME Annie B. CLATTERBUCK | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Floyd W. LEAVELL Route 4, Culpeper, Virginia | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure & pulmonary edema 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Resection of thoracic esophagus DUE TO (c) Carcinoma of the esophagus | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days 8 days 5-6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from May 6 , 19 57 , to June 1 , 19 57 , that I last saw the deceased alive on June 1 , 19 57 , and that death occurred at 3:07AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-1-57 | | | | | | | |
| ACTUAL SIGNATURE Robert P. DOBBIE, M.D. | | | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) Robert P. DOBBIE, M.D. | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-3-57 | | 22c. NAME OF CEMETERY OR CREMATORY National Cemetery | | 22d. LOCATION (City, town, or county) (State) Culpeper, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Geest Funeral Parlors, Culpeper, Virginia | | | | 24a. REC'D BY REGISTRAR DATE 6-1-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | |

BUREAU V. S.

JUN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6539

CERTIFICATE OF DEATH

Reg. Dist. No.

06514

216

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>CHEVY CHASE MD.</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN lb <u>22 hrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN EVA</u> <u>LELAND</u> | | 4. DATE OF DEATH Month Day Year <u>JUNE 27</u> <u>19 57</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 13 - 1890</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>7</u> <u>14</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>RICHARD T. BUTLER</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH HALL</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>578-38-7004D</u> | |
| 17. INFORMANT <u>Charles B. Redmond</u> | | Address <u>0032 Woodhill Rd. Bethesda, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Toxemia</u> DUE TO (c) <u>Carcinomatosis advanced</u> | | INTERVAL BETWEEN ONSET AND DEATH, <u>3 min</u> <u>6 mo</u> <u>6 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>absence of one kidney surgically removed</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>MAR.</u> 19 <u>53</u> , to <u>JUNE 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 27</u> , 19 <u>57</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John O. Robben</u> M.D. | | ADDRESS (Street, city or town, state) <u>7930 Georgia Ave. Silver Spring, Md.</u> | |
| DATE SIGNED <u>6-30-57</u> | | DATE SIGNED <u>6-30-57</u> | |
| PHYSICIAN'S NAME (Type) <u>John O. Robben</u> | | 7930 Georgia Ave. Silver Spring, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7-1-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Pumphrey</u> | | ADDRESS <u>Bethesda, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 6-30-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------|--|----------------|--|------------------|--|-------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | OCCUPATION | |
| JAMES W. BUTLER | | M | | 45 | | JAN 15 1912 | | BALTIMORE, MD | | FIREMAN | |
| RESIDENCE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF PHYSICIAN | |
| 1234 E. BALTIMORE ST. | | JUL 1 1957 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | J. W. SMITH, M.D. | |
| FATHER'S NAME | | MOTHER'S NAME | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | OCCUPATION OF FATHER | | OCCUPATION OF MOTHER | |
| JAMES W. BUTLER | | MARY E. BUTLER | | JAN 15 1912 | | BALTIMORE, MD | | FIREMAN | | HOUSEWIFE | |

RECEIVED
JUL 2 1957
BUREAU V. S.

| | | | | | | | | | | | |
|-----------------|--|----------------|--|------------------|--|-------------------|--|------------------------|--|------------------------|--|
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| JUL 1 1957 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | J. W. SMITH, M.D. | | J. W. SMITH, M.D. | |
| FATHER'S NAME | | MOTHER'S NAME | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | OCCUPATION OF FATHER | | OCCUPATION OF MOTHER | |
| JAMES W. BUTLER | | MARY E. BUTLER | | JAN 15 1912 | | BALTIMORE, MD | | FIREMAN | | HOUSEWIFE | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6540

CERTIFICATE OF DEATH

06515

Reg. Dist. No.

214

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ASHTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-ASHTON XI</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ASHTON, COLESVILLE RD</u> | | d. STREET ADDRESS <u>COLESVILLE RD 1</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE LYMAN LEMERLE</u> | | 4. DATE OF DEATH Month Day Year <u>6-13-1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 12, 1864</u> |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PHYSICIAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>AUGUSTUS EUGENE LEMERLE</u> | | 14. MOTHER'S MAIDEN NAME <u>AIETTA MARR</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>EUGENIE L. RIGGS, ASHTON, MD</u> | |
| 17. INFORMANT Address <u>EUGENIE L. RIGGS, ASHTON, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hamiplegia Left.</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Broncho-Pneumonia</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>6 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>6/5</u> , 19 <u>57</u> , to <u>6/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/7</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. M. BIRD</u> | | ADDRESS (Street, city or town, state) <u>Sanby Sp</u> DATE SIGNED <u>6/13/57</u> | |
| PHYSICIAN'S NAME (Type) <u>J. M. BIRD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | 22b. DATE THEREOF <u>6/17/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Pawluszewski</u> ADDRESS <u>1756 Pa. Ave., N.W. DC</u> | | 24a. REC'D BY REGISTRAR <u>JUN 17 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|-----------------------|--|----------------------|--|-----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5, 1928 | | MOBILE, ALABAMA | | MOBILE | | ALABAMA | | UNITED STATES | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | | CITY | |
| SALES REPRESENTATIVE | | HIGH SCHOOL | | MARRIED | | METHODIST | | HEART DISEASE | | SUICIDE | | MOBILE | | ALABAMA | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | DATE OF BURIAL | | PLACE OF BURIAL | | CITY | |
| JAN 17, 1968 | | MOBILE | | ALABAMA | | UNITED STATES | | UNITED STATES | | JAN 17, 1968 | | MOBILE | | ALABAMA | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF MINISTER | | SIGNATURE OF CORONER | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 17, 1968 | | JAN 17, 1968 | | JAN 17, 1968 | | JAN 17, 1968 | | JAN 17, 1968 | | JAN 17, 1968 | | JAN 17, 1968 | | JAN 17, 1968 | |

BUREAU, W.S.

JAN 17 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6450

CERTIFICATE OF DEATH

Reg. Dist. No.

06516
223

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|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| 6. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>6 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hospital</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 17 | | | |
| d. STREET ADDRESS <u>105 Hodges Lane</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Colin Shaw Lewis</u> | | | | 4. DATE OF DEATH <u>June 3 1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-12-84</u> | |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Employed</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DRY GOODS</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>David Lewis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eliza HORRELL</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Hospital Records.</u> | | | |
| 17. INFORMANT <u>Hospital Records.</u> Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>350X Parkinson's Disease, Advanced</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>57</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>25 May 1957</u> , to <u>3 June 1957</u> , that I last saw the deceased alive on <u>2 June 1957</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>7112 Wallow Dr 3 June 1957</u> | | | | DATE SIGNED <u>1957</u> | | | |
| ACTUAL SIGNATURE <u>H. B. Queen</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u> | | | | <u>Takoma Park, Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>buried</u> | | <u>June 5, 1957</u> | | <u>Winton Park Cemetery</u> | | <u>Wilmington, North Carolina</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll Ave. N.W. D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>June 9 - 1957</u> 24b. REGISTRAR'S SIGNATURE <u>William Dodd</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1957

BUREAU V. S.

| | |
|-----------------------------|------------------------------|
| 15. Name of the deceased | 16. Date of death |
| 17. Place of death | 18. Cause of death |
| 19. Name of the physician | 20. Name of the funeral home |
| 21. Name of the next of kin | 22. Name of the informant |

23. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

24. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

25. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

26. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

27. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

28. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

29. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

30. I certify that I attended the deceased from _____ to _____ and that death occurred on _____ at _____

Hospital Records

Eliza

N.C.

9-12-24

Shaw House

David Lewis

Self Employed

Male White

Colin

St. Joseph's Hospital

Taken to Park

St. Joseph's

CERTIFICATE OF DEATH

INDEPENDENT STATE OF ILLINOIS - BAYLOR COUNTY

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6541
Items 8,9:G217 7-2-57 L

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|--|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | | | c. LENGTH OF STAY IN 1b 3 yrs. 1 Mo. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall San. 10231 Carroll Place | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) NAN TRAVIS | | | | 4. DATE OF DEATH June 23, 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1888 Dec. 27, 1888 | |
| 9. AGE (In years last birthday) 68 78 yrs. | | IF UNDER 1 YEAR 5 Months | | IF UNDER 24 HRS. 26 Days | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Capital Transit | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | | | | | | |
| 13. FATHER'S NAME Frank M. Travis | | | | 14. MOTHER'S MAIDEN NAME Betty B. Collawn | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Son Address Louis C. Paladini 3705 Dunlop St. Chevy Chase, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDITIS (c) CHRONIC MYOCARDITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X CEREBRAL SCLEROSIS | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from MAY 23, 1954 , to JUNE 23, 1957 , that I last saw the deceased alive on JUNE 23, 1957 , and that death occurred at 4:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Henry M. Lowden | | | | ADDRESS (Street, city or town, state) 5206 Norway St. 6/23/57 | | | |
| DATE SIGNED 6/23/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Henry M. Lowden | | | | Cheng Chou, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-26-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Pumphrey ADDRESS Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 6-24-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6542

CERTIFICATE OF DEATH

06518

Reg. Dist. No.

| | | | |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8212 CUSTER RD. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle J Last MacKAVANAGH | | 4. DATE OF DEATH Month 6 Day 4 Year 1957 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 25, 1882 |
| 9. AGE (In years last birthday) yrs. 75 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lawyer & Electrical Engineer Scotland | | 11. BIRTHPLACE (State or foreign country) Scotland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME James MacKavanagh | |
| 14. MOTHER'S MAIDEN NAME Mary Coyle | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. 577-07-1543-A | | 17. INFORMANT Rev. Kelgin J. MacKavanagh | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) united | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. , 1955, to June 4 , 1957, that I last saw the deceased alive on June 4 , 1957, and that death occurred at 4:55 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. Willard Camalier, Jr. | | ADDRESS (Street, city or town, state) 1801-Eye St. N.W. Wash. D.C. | |
| PHYSICIAN'S NAME (Type) C. WILLARD CAMALIER, JR. | | DATE SIGNED 6/4/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/6/57 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D. C. | | 24a. REC'D BY REGISTRAR Bessie Thompson | |
| 24b. REGISTRAR'S SIGNATURE | | DATE JUN 6 1957 | |

RECEIVED
JUN 6 1957
BUREAU V. 3

CERTIFICATE OF DEATH

Reg. Dist. No.

214

6543

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9810 Georgia Ave. Maple Lane Rest Home | | e. STREET ADDRESS 1851 Columbia Rd., N.W. | |
| 3. NAME OF DECEASED (Type or print) Margaret Ryan Marshall | | 4. DATE OF DEATH Month June Day 26 Year 1957 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 25, 1877 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph N. Ryan | | 14. MOTHER'S MAIDEN NAME Lucy F. McCormick | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Arthur D. Yewell, 6609 Oxtown Road, | | Address Bethesda, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X acute myocarditis DUE TO (b) cardio vascular revascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH 4 da 2 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 431X | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 6, 1957 to June 26, 1957 , that I last saw the deceased alive on June 25, 1957 , and that death occurred at 6:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1822 Biltmore St NW Wash D.C. DATE SIGNED June 26 57 | | | |
| ACTUAL SIGNATURE E. E. Quayle M.D. | | PHYSICIAN'S NAME (Type) E. E. Quayle | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 6/29/57 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Old Chapel Cemetery | | 22d. LOCATION (City, town, or county) (State) Berryville, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. | | ADDRESS Wash. D.C. | |
| 24a. REC'D BY REGISTRAR JUN 28 1957 | | 24b. REGISTRAR'S SIGNATURE Frances Patten | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|--|--|-----------------------------------|---|--|---|----------------------------------|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Reg. Dist. No. 06520 278 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>MONTG</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P. G.</u> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Dr 16x2.2</u> | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pot. R. 1 1/2 mi. above St. Jacks</u> | | | | | d. STREET ADDRESS <u>2531 Colbrook Dr.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>James Preston Mays Jr</u> | | | | | 4. DATE OF DEATH Month Day Year <u>June 26 1957</u> | | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-9-1949</u> | | 9. AGE (In years last birthday) <u>8</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>DC</u> | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 13. FATHER'S NAME <u>James Preston Mays Sr</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Constance Phillips</u> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address <u>James R. Mays Sr - Same # 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephroses</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>drowning</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>929.8</u> | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stepped into deep water while fishing</u> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>3:25</u> P. M. <u>6/26 1957</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac R</u> | | 20f. (City or town) <u>Potomac Montg MD</u> (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCHECH</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | 22b. DATE THEREOF <u>6-27-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamberlain</u> | | | | | ADDRESS <u>517-11th St. S.E.</u> | | 24a. REC'D BY REGISTRAR <u>June 28 1957</u> | | | | |
| | | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Linell Lupton</u> | | | | |

MAINE STATE DEPARTMENT OF HEALTH - BATHING 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|-----------------------|--|------------------|--|----------------------|--|--------------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | |
| PLACE OF DEATH | | CITY | | COUNTY | | STATE | | HOURS OF DEATH | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | |
| HISTORY OF DEATH | | PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | |
| FAMILY HISTORY | | SOCIAL HISTORY | | OCCUPATION | | EDUCATION | | RELIGION | |
| FINDINGS AT AUTOPSY | | GROSS FINDINGS | | MICROSCOPIC FINDINGS | | HISTOPATHOLOGIC FINDINGS | | TOXICOLOGIC FINDINGS | |
| LABORATORY TESTS | | BACTERIOLOGIC | | CHEMIST | | PHYSICIAN | | PATHOLOGIST | |
| SIGNATURE OF EXAMINER | | DATE | | PLACE | | COUNTY | | STATE | |

BUREAU V. 2

JUN 28 1957

RECEIVED

6545

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Columbia | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 7 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Mazal | | | | 4. DATE OF DEATH Month June Day 7th Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 14th, 1920 36 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Hand | | 10b. KIND OF BUSINESS OR INDUSTRY Manufacturing | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Arthur Mazal | | | | 14. MOTHER'S MAIDEN NAME Nellie Sitzler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 074-14-9300 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9 DUE TO Intoxications + intra abdominal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancreatic metastases DUE TO Chromocarcinoma, status post panhystec 11/56 - 6/57 (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6/4 - 6/7 | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 31st , 19 57 , to June 7th , 19 57 , that I last saw the deceased alive on June 7th , 19 57 , and that death occurred at 6:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/7/57 ACTUAL SIGNATURE Peter D. Olch M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Peter D. Olch, M. D. Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 22b. DATE THEREOF 6/7/57 | | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 22d. LOCATION (City, town, or county) (State) Niverville, New York | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 6-8-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of New York

New York

County of New York

City of New York

Married

Single

Widow

1234 Main Street

Male

Female

Age

June 11, 1957

Time

Place

New York

Manhasset Neck

Manhasset Neck

John Doe

John Doe

06-11-57

No

BUREAU V. 2

JUN 11 1957

RECEIVED

6546

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Prigley's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Neen's Nursing Home | | d. STREET ADDRESS 5000-Linington Rd S | |
| 3. NAME OF DECEASED (Type or print) First BENSON Middle P Last MCDANIEL | | 4. DATE OF DEATH Month JUNE Day 2 Year 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT. 16, 1875 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Guard | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Thomas McDaniel | | 14. MOTHER'S MAIDEN NAME Not known | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Jane Cox | | Address 121 Salisbury Dr. S.E. Wash, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 4 days. 5 years. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4341 congestive Heart Failure. | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 12, 1957 , to June 2, 1957 , that I last saw the deceased alive on June 2, 1957 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James A. Roberts | | ADDRESS (Street, city or town, state) 8907 GEORGIA AVE | |
| PHYSICIAN'S NAME (Type) JAMES A. ROBERTS M.D. | | DATE SIGNED 6/2/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 22b. DATE THEREOF 6-5-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Shiloh Meth. Cemetery | | 22d. LOCATION (City, town, or county) (State) Pomonkey MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Demmons Bros. | | ADDRESS 1661-Hood Hope Rd. Wash DC | |
| 24a. REC'D BY REGISTRAR JUN 4 1957 | | 24b. REGISTRAR'S SIGNATURE Frank Potter | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2411 40x0

1946, 1947.

2521, 1852

15/12/11.

1875-1876

2700

2000

27 June 1941

[Faint handwritten notes at the bottom of the page, possibly "L. 2018-19"]

James W. Roberts

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6547

CERTIFICATE OF DEATH

06523

Reg. Dist. No.

217

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Maryd | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 4 hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital | | | | d. STREET ADDRESS 305 Wasp Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mc Lain | | | | 4. DATE OF DEATH Month Day Year June 11 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/11/57 | |
| 9. AGE (In years last birthday) yrs. 4 | | IF UNDER 1 YEAR Months Days Hours Min. 4 | | IF UNDER 24 HRS. Months Days Hours Min. 4 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME George Henry McLain | | | | 14. MOTHER'S MAIDEN NAME Shirley Louise Youngman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mother | | Address Same #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cum prematurity - wt. 1-3 3/4 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 hrs | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Prince George's Co., Md. | | | | 20g. (County) Prince George's Co., Md. | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from 6/11 , 19 57 , to 6/11 , 19 57 , that I last saw the deceased alive on 6/11 , 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Bonifant M.D. Sandy Spring, Md. PHYSICIAN'S NAME (Type) A. D. Bonifant, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation June 12, 1957 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State) Prince George's Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey | | | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR DATE 6/14/57 | |
| 24b. REGISTRAR'S SIGNATURE Stanley B. Lavelle | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6451

CERTIFICATE OF DEATH

06524 223
 Reg. Dist. No.

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|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | | c. LENGTH OF STAY IN 1b 4 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PINEY POINT 18x22 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVENUE Oak Haven Conv. Home | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) XXXXXXXXXX PHILIP JACKSON Middle MEDLEY Last | | | | DATE OF DEATH | | Month JUNE Day 10 Year 1957 | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/21/62 | |
| 9. AGE (In years last birthday) 94 yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Owner | | 11. BIRTHPLACE (State or foreign country) St. Mary's County, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME CHARLES MEDLEY | | | | 14. MOTHER'S MAIDEN NAME LOUISA ALLSTON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Mr. J. Ingram Medley, 7840 Aberdeen Rd. Bethesda, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492x Wind Pneumonia DUE TO (b) Infection plus pneumonia DUE TO (c) Plus 94+ age CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3-4 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1953 , 19____, to June 10, 1957 that I last saw the deceased alive on May 31, 1956 , and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 506 New and New Wash, DC DATE SIGNED 6/10/57 | | | | | | | |
| ACTUAL SIGNATURE Chas H. Wolohon M.D. | | | | PHYSICIAN'S NAME (Type) Chas H. Wolohon | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/13/57 | | 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD. | | | | 24a. REC'D BY REGISTRAR DATE 6/14/57 | | 24b. REGISTRAR'S SIGNATURE J. Wilson Smith | |

BUREAU V. S.

JUN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6548

CERTIFICATE OF DEATH

06525

Reg. Dist. No. 216

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 19-E. Lenox | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Walter Curran Mendenhall | | 4. DATE OF DEATH Month Day Year June 2, 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-20-1871 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director | | 10b. KIND OF BUSINESS OR INDUSTRY Geological Survey | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wm K. Mendenhall | | 14. MOTHER'S MAIDEN NAME Emma Pierce | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Alcie Mendenhall | | Address 9 E. Lenox Ch. Ch. Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from Gastrointestinal Tract DUE TO 153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Suspect Carcinoma COLON DUE TO (c) — | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1955 , to June 2, 1957 that I last saw the deceased alive on June 2, 1957 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Peyton R Evans Jr | | ADDRESS (Street, city or town, state) 5401 Western Ave NW | |
| PHYSICIAN'S NAME (Type) PEYTON R. EVANS JR | | DATE SIGNED 6-3-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 6-4-57 | | 22b. DATE THEREOF 6-4-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Suitland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Sons, Wash D.C. | | ADDRESS Wash D.C. | |
| 24a. REC'D BY REGISTRAR DATE 6-6-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

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|---|--|---|--|
| NAME OF DECEASED [Faint handwritten name] | | SEX [Faint handwritten sex] | |
| AGE [Faint handwritten age] | | DATE OF BIRTH [Faint handwritten date] | |
| PLACE OF BIRTH [Faint handwritten place] | | DATE OF DEATH [Faint handwritten date] | |
| CAUSE OF DEATH [Faint handwritten cause] | | PLACE OF DEATH [Faint handwritten place] | |
| TIME OF DEATH [Faint handwritten time] | | SIGNATURE OF PHYSICIAN [Faint handwritten signature] | |
| SIGNATURE OF REGISTRAR [Faint handwritten signature] | | OFFICIAL USE [Faint handwritten notes] | |

BUREAU V. 2

JUN 10 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06526

6549

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE District of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Chevy Chase) Washington 478-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital | | d. STREET ADDRESS 5201 Chevy Chase Parkway, NW | |
| 3. NAME OF DECEASED (Type or print) First Essie Middle Lucretia Last MICHAELIS | | 4. DATE OF DEATH Month June Day 10 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 4 1880 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Unknown (GISE) | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Son, Joseph L. MICHAELIS | | Address Wheaton, Maryland 11906 Garner St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular Fibrillation (c) Atherosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH 6 days 4 mos. unk - | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 433.1 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 5 , 19 57 , to June 10 , 19 57 , that I last saw the deceased alive on June 10 , 19 57 , and that death occurred at 9:58 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-11-57 | | | |
| ACTUAL SIGNATURE Thomas S. Dunn, Jr. | | M.D. U.S. Naval Hospital, Bethesda, Md. | |
| PHYSICIAN'S NAME (Type) Thomas S. DUNN, Jr. LT MG USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-14-57 | 22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, Dist. of Columbia |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee Sons, 4th & Mass. Ave., N.E., Wash., | | 24. REC'D BY REGISTRAR DATE 6-11-57 | |
| 24. REGISTRAR'S SIGNATURE Mary E. Farrelly | | | |

CERTIFICATE OF DEATH

MAKLAND STATE DEPARTMENT OF HEALTH - BATHING, 19

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BUREAU V. R.

JUN 12 1957

RECEIVED

6452

CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | |
|---|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>Washington DC</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC. 47x-3</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u> | | | d. STREET ADDRESS <u>44 21 48th St. N.W.</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>Axel</u> First <u>Conrad</u> Middle <u>Millbrook</u> Last | | | 4. DATE OF DEATH <u>June 30</u> Month <u>June</u> Day <u>30</u> Year <u>1957</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/3/1887</u> | 9. AGE (In years last birthday) <u>70</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Corson-Gruman)</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Engineer Sweden</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Sweden</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>Sweden</u> | | |
| 13. FATHER'S NAME <u>Axel M. Millbrook</u> | | | 14. MOTHER'S MAIDEN NAME <u>Anna Anderson</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>Hospital Records</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Chronic pyelonephritis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u> <u>30 hrs</u> <u>1-2 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>5/24</u> 19 <u>57</u> to <u>June 30 1957</u> that I last saw the deceased alive on <u>June 30</u> , 19 <u>57</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Arthur J. Wilets</u> | | | ADDRESS (Street, city or town, state) <u>909 Pnsing Drive, Silver Spring, Md.</u> DATE SIGNED <u>6/30/57</u> | | |
| PHYSICIAN'S NAME (Type) <u>Arthur J. Wilets</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7/3/1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901-14th St</u> | | | 24a. REC'D BY REGISTRAR <u>J. Wilets</u> ADDRESS <u>WASH. D. C. N. W.</u> | | |
| | | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilets</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED <i>JOHN J. BROWN</i> | | 2. SEX <i>MALE</i> | | 3. AGE <i>45</i> | | 4. OCCUPATION <i>LABORER</i> | |
| 5. PLACE OF BIRTH <i>NEW YORK</i> | | 6. DATE OF BIRTH <i>1912</i> | | 7. PLACE OF DEATH <i>BALTIMORE</i> | | 8. DATE OF DEATH <i>1957</i> | |
| 9. CAUSE OF DEATH <i>HEART DISEASE</i> | | 10. MANNER OF DEATH <i>NATURAL</i> | | 11. PLACE OF INTERMENT <i>CATHOLIC CHURCH</i> | | 12. DATE OF INTERMENT <i>1957</i> | |
| 13. SIGNATURE OF PHYSICIAN <i>[Signature]</i> | | 14. SIGNATURE OF REGISTRAR <i>[Signature]</i> | | 15. SIGNATURE OF DECEASED <i>[Signature]</i> | | 16. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 17. SIGNATURE OF DECEASED <i>[Signature]</i> | | 18. SIGNATURE OF WITNESS <i>[Signature]</i> | | 19. SIGNATURE OF DECEASED <i>[Signature]</i> | | 20. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 21. SIGNATURE OF DECEASED <i>[Signature]</i> | | 22. SIGNATURE OF WITNESS <i>[Signature]</i> | | 23. SIGNATURE OF DECEASED <i>[Signature]</i> | | 24. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 25. SIGNATURE OF DECEASED <i>[Signature]</i> | | 26. SIGNATURE OF WITNESS <i>[Signature]</i> | | 27. SIGNATURE OF DECEASED <i>[Signature]</i> | | 28. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 29. SIGNATURE OF DECEASED <i>[Signature]</i> | | 30. SIGNATURE OF WITNESS <i>[Signature]</i> | | 31. SIGNATURE OF DECEASED <i>[Signature]</i> | | 32. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 33. SIGNATURE OF DECEASED <i>[Signature]</i> | | 34. SIGNATURE OF WITNESS <i>[Signature]</i> | | 35. SIGNATURE OF DECEASED <i>[Signature]</i> | | 36. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 37. SIGNATURE OF DECEASED <i>[Signature]</i> | | 38. SIGNATURE OF WITNESS <i>[Signature]</i> | | 39. SIGNATURE OF DECEASED <i>[Signature]</i> | | 40. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 41. SIGNATURE OF DECEASED <i>[Signature]</i> | | 42. SIGNATURE OF WITNESS <i>[Signature]</i> | | 43. SIGNATURE OF DECEASED <i>[Signature]</i> | | 44. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 45. SIGNATURE OF DECEASED <i>[Signature]</i> | | 46. SIGNATURE OF WITNESS <i>[Signature]</i> | | 47. SIGNATURE OF DECEASED <i>[Signature]</i> | | 48. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 49. SIGNATURE OF DECEASED <i>[Signature]</i> | | 50. SIGNATURE OF WITNESS <i>[Signature]</i> | | 51. SIGNATURE OF DECEASED <i>[Signature]</i> | | 52. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 53. SIGNATURE OF DECEASED <i>[Signature]</i> | | 54. SIGNATURE OF WITNESS <i>[Signature]</i> | | 55. SIGNATURE OF DECEASED <i>[Signature]</i> | | 56. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 57. SIGNATURE OF DECEASED <i>[Signature]</i> | | 58. SIGNATURE OF WITNESS <i>[Signature]</i> | | 59. SIGNATURE OF DECEASED <i>[Signature]</i> | | 60. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 61. SIGNATURE OF DECEASED <i>[Signature]</i> | | 62. SIGNATURE OF WITNESS <i>[Signature]</i> | | 63. SIGNATURE OF DECEASED <i>[Signature]</i> | | 64. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 65. SIGNATURE OF DECEASED <i>[Signature]</i> | | 66. SIGNATURE OF WITNESS <i>[Signature]</i> | | 67. SIGNATURE OF DECEASED <i>[Signature]</i> | | 68. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 69. SIGNATURE OF DECEASED <i>[Signature]</i> | | 70. SIGNATURE OF WITNESS <i>[Signature]</i> | | 71. SIGNATURE OF DECEASED <i>[Signature]</i> | | 72. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 73. SIGNATURE OF DECEASED <i>[Signature]</i> | | 74. SIGNATURE OF WITNESS <i>[Signature]</i> | | 75. SIGNATURE OF DECEASED <i>[Signature]</i> | | 76. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 77. SIGNATURE OF DECEASED <i>[Signature]</i> | | 78. SIGNATURE OF WITNESS <i>[Signature]</i> | | 79. SIGNATURE OF DECEASED <i>[Signature]</i> | | 80. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 81. SIGNATURE OF DECEASED <i>[Signature]</i> | | 82. SIGNATURE OF WITNESS <i>[Signature]</i> | | 83. SIGNATURE OF DECEASED <i>[Signature]</i> | | 84. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 85. SIGNATURE OF DECEASED <i>[Signature]</i> | | 86. SIGNATURE OF WITNESS <i>[Signature]</i> | | 87. SIGNATURE OF DECEASED <i>[Signature]</i> | | 88. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 89. SIGNATURE OF DECEASED <i>[Signature]</i> | | 90. SIGNATURE OF WITNESS <i>[Signature]</i> | | 91. SIGNATURE OF DECEASED <i>[Signature]</i> | | 92. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 93. SIGNATURE OF DECEASED <i>[Signature]</i> | | 94. SIGNATURE OF WITNESS <i>[Signature]</i> | | 95. SIGNATURE OF DECEASED <i>[Signature]</i> | | 96. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 97. SIGNATURE OF DECEASED <i>[Signature]</i> | | 98. SIGNATURE OF WITNESS <i>[Signature]</i> | | 99. SIGNATURE OF DECEASED <i>[Signature]</i> | | 100. SIGNATURE OF WITNESS <i>[Signature]</i> | |

BUREAU V. 2

3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

6550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13 Film 9216 6-17-57 et

06528

Reg. Dist. No.

216

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>7 mo</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10208 Fleming Ave</u> | | | | d. STREET ADDRESS <u>110208 Fleming Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ray</u> Last <u>Millie</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1957</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-21-1899</u> | |
| 9. AGE (in years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> | | IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt Navy</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Agnes McKie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. <input type="checkbox"/> | | 17. INFORMANT <u>Flourence Millie Sam</u> Address <u>#2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> stating the underlying cause lost. (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/13/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>6-11-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | | |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 12 1957

RECEIVED

6551

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN IB 1 month 28 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital | | | |
| d. STREET ADDRESS 4700 Bradley Boulevard | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Isabelle Last MILSTEAD | | | | 4. DATE OF DEATH Month June Day 7 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 25, 1891 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) District of Columbia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Thomas Kenneth MORGAN | | | | 14. MOTHER'S MAIDEN NAME Blanche R. PADGETT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Husband, Wallace A. MILSTEAD (Same as #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grand Mal Convulsions + inanition DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Metastatic lesions from DUE TO Carcinoma, uterus (endometrium) (c) indefinite 1 1/2 yrs + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 10, 1957 , to June 7, 1957 , that I last saw the deceased alive on June 7, 1957 , and that death occurred at 4:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George L. Johnson, Jr., U.S. Naval Hospital, Bethesda, Md. 6-7-57 | | | | | | | |
| ACTUAL SIGNATURE George L. Johnson, Jr. | | | | PHYSICIAN'S NAME (Type) George L. Johnson, Jr., LTMCUSN/U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-10-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 6-7-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Farrelly | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REGISTRATION NO. 515

| | | | | | |
|-------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Death | | Place of Death | |
| J. J. J. J. J. J. | | June 10, 1957 | | J. J. J. J. J. | |
| Age | | Sex | | Race | |
| J. J. J. J. J. | | Male | | White | |
| Marital Status | | Cause of Death | | Place of Burial | |
| Single | | J. J. J. J. J. | | J. J. J. J. J. | |
| Occupation | | Signature of Physician | | Signature of Registrar | |
| J. J. J. J. J. | | J. J. J. J. J. | | J. J. J. J. J. | |
| Date of Birth | | Date of Death | | Date of Burial | |
| J. J. J. J. J. | | June 10, 1957 | | June 10, 1957 | |
| Place of Birth | | Place of Death | | Place of Burial | |
| J. J. J. J. J. | | J. J. J. J. J. | | J. J. J. J. J. | |
| Date of Death | | Date of Burial | | Date of Interment | |
| June 10, 1957 | | June 10, 1957 | | June 10, 1957 | |
| Place of Death | | Place of Burial | | Place of Interment | |
| J. J. J. J. J. | | J. J. J. J. J. | | J. J. J. J. J. | |
| Date of Death | | Date of Burial | | Date of Interment | |
| June 10, 1957 | | June 10, 1957 | | June 10, 1957 | |
| Place of Death | | Place of Burial | | Place of Interment | |
| J. J. J. J. J. | | J. J. J. J. J. | | J. J. J. J. J. | |

BUREAU V. S.

JUN 10 1957

RECEIVED

6552

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Vermont b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 9 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Albans 82 X-3 | |
| f. STREET ADDRESS 135 Federal Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mena Middle Delma Last Miner | | 4. DATE OF DEATH Month June Day 11 , Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 9, 1930 |
| 9. AGE (In years lost birthday) 26 yrs. | | 10. IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min. | 11. IF UNDER 24 HRS. Hours 26 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | |
| 11. BIRTHPLACE (State or foreign country) Vermont | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Julius Paquette | | 14. MOTHER'S MAIDEN NAME Stella Mercey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 008-20-6316 | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Air Embolism 754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Open Heart Surgery DUE TO (c) Congenital Heart disease Atrial Septal Defect | | INTERVAL BETWEEN ONSET AND DEATH 30 min 26 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 2, 19 57 , to June 11, 19 57 , that I last saw the deceased alive on June 11, 19 57 , and that death occurred at 12:29 P. , from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) The Clinical Center | | DATE SIGNED 6/17/57 | |
| ACTUAL SIGNATURE Clarence E. Weldon, M. D. | | NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 22b. DATE THEREOF 6/15/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary | | 22d. LOCATION (City, town, or county) (State) St. Albans, Vermont | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR 6-14-57 | | 24b. REGISTRAR'S SIGNATURE Beanie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 17 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06531

6453

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b 1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | d. STREET ADDRESS 1746 Lamont St., N. W. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last John Phillip Morris | | 4. DATE OF DEATH Month Day Year June 26 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 26, 1893 |
| 9. AGE (In years lost birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 12. KIND OF BUSINESS OR INDUSTRY Painting | |
| 13. FATHER'S NAME Green L. Morris | | 14. MOTHER'S MAIDEN NAME Nancy Hodges | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW #1 | |
| 17. INFORMANT Hugh Morris, 3048 Oliver St., N. W. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute aortic aneurysm DUE TO 280x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Beri Beri heart disease DUE TO (c) Arteriosclerosis - generalized | | INTERVAL BETWEEN ONSET AND DEATH 36 hrs 3 mo 7 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450. Malnutrition (severe) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-25 , 19 57 , to 6-26 , 19 57 , that I last saw the deceased alive on 6-26 , 19 57 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Wash. 10, D. C. DATE SIGNED | | | |
| ACTUAL SIGNATURE S. H. Markwood M.D. | | | |
| PHYSICIAN'S NAME (Type) E. H. Markwood, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 28, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 22d. LOCATION (City, town, or county) (State) Fort Myer, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wanner & Humphrey | | 24a. REC'D BY REGISTRAR DATE 6/19/57 | |
| ADDRESS Silver Spring, Md | | 24b. REGISTRAR'S SIGNATURE J. H. [Signature] | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

JUL 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6553

06532

Reg. Dist. No. *216*

| | | | | | | | |
|---|------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY in 1b 1 Hour 10 Min | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington KENSINGTON X2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban | | | | d. STREET ADDRESS 3932 Washington St., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mary Avondale First MOULTON Middle MOULDEN Last | | | | 4. DATE OF DEATH Month June Day 26 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 20, 1894 | 9. AGE (In years last birthday) 72 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Maryland, Mont. County | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William V. Beall | | | | 14. MOTHER'S MAIDEN NAME Mary Purdum | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Eleanor M. Cervenka Address 3932 Washington Street Kensington, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) FRANK J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6-26-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY | | 22d. LOCATION (City, town, or county) (State) ROCKVILLE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD. | | | | 24a. REC'D BY REGISTRAR DATE 6-30-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6554
CERTIFICATE OF DEATH

06533211
Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodfield | | c. LENGTH OF STAY IN 1b 10 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gaithersburg BFD # I | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodfield | |
| 3. NAME OF DECEASED (Type or print) GEORGE First DAVID Middle MOYER Last | | 4. DATE OF DEATH Month JUNE Day II Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept, 10 1877 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ambrose Moyer | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth Stormback | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 217 32 1309 | |
| 17. INFORMANT Harriet M. Moyer, | | Address Same As #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Atherosclerosis of the cardiovascular disease 104.0 DUE TO (c) 104.0 | | INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 11 , 19 57 , to June 11 , 19 57 , that I last saw the deceased alive on June 11 , 19 57 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James P. Kerr | | ADDRESS (Street, city or town, state) Damascus, Md. | |
| PHYSICIAN'S NAME (Type) James P. Kerr | | DATE SIGNED 6/13/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 14 57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 22d. LOCATION (City, town, or county) (State) Prince George Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Coy W. Barber | | 24a. REC'D BY REGISTRAR June 14/57 | |
| ADDRESS Laytonsville, Md. | | 24b. REGISTRAR'S SIGNATURE Della M. Bussell | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06534

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

6555

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp. | | | | d. STREET ADDRESS 5148 Mass. Ave. | | | |
| 3. NAME OF DECEASED (Type or print) First Bernadette Middle M. Last Mulqueen | | | | 4. DATE OF DEATH Month 6 Day 6 Year 19 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/19/57 1900 | 9. AGE (In years last birthday) 56 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Cauley | | | | 14. MOTHER'S MAIDEN NAME Mary Welch | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hosp. Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration + hemorrhage, Pons 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fall down stairs DUE TO (c) multiple lacerations cerebral cortex | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) multiple lacerations cerebral cortex | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stair steps at home | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 1:30 o. m. 6/1/57 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) (County) (State) Bethesda Montg Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 6/7/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/10/57 | | 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | 22d. LOCATION (City, town, or county) (State) Montgomery County Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley Sons | | | | ADDRESS 1756 Pa. Ave., N.W. | | 24a. REC'D BY REGISTRAR DATE 6-11-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|----------------|--|
| Name of Deceased | | John C. Kelley | |
| Sex | | Male | |
| Age | | 60 | |
| Date of Birth | | 1900 | |
| Place of Birth | | Boston, Mass. | |
| Usual Residence | | 1000 | |
| Cause of Death | | Heart Disease | |
| Manner of Death | | Natural | |
| Signature of Medical Examiner | | [Signature] | |
| Date of Death | | June 12, 1957 | |

BUREAU V. 1

JUN 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6556

CERTIFICATE OF DEATH

06535
Reg. Dist. No.

216

| | | | | | | | |
|--|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3812 Woodbine St. | | | | d. STREET ADDRESS 1 3812 Woodbine St. | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Spencer Last Nesbitt | | | | 4. DATE OF DEATH Month June Day 25 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 27, 1905 | 9. AGE (In years last birthday) yrs. 51 | IF UNDER 1 YEAR Months 5 Days 28 | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Officer-Retired. U.S. Army | | | | 10b. KIND OF BUSINESS OR INDUSTRY Kentucky | | 11. BIRTHPLACE (State or foreign country) U. S. | |
| 13. FATHER'S NAME William F. Nesbitt | | | | 14. MOTHER'S MAIDEN NAME Florence S. Spencer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Wife Alice M. Nesbitt | | Address Same as Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO CORONARY THROMBOSIS & INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC HYPERTENSION DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 MINS 2 DAYS 8 YRS. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 444X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from 10-17 , 19 51 , to 6-19 , 19 57 , that I last saw the deceased alive on 6-19 , 19 57 , and that death occurred at 6:55 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Harold Sterling M.D. | | | ADDRESS (Street, city or town, state) 1352 University Lane, Hyattsville, Md. | | | | |
| PHYSICIAN'S NAME (Type) Harold Sterling | | | DATE SIGNED 6/26/57 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/28/57 | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | 22d. LOCATION (City, town, or county) Arlington, Virginia | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR 6-27-57 | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------|--|-------------|--|------------------|--|-------------------|--|------------------|--|------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Place of birth | | 6. Date of death | | 7. Place of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | | 11. Signature of registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1910 | | New York City | | Jan 15, 1957 | | Baltimore, MD | | Heart Disease | | Natural | | [Signature] | | [Signature] | |
| 12. Name of informant | | 13. Relationship | | 14. Address | | 15. City | | 16. State | | 17. Zip | | 18. Date of completion | | 19. Signature of informant | | 20. Signature of registrar | | 21. Signature of physician | | 22. Signature of registrar | |
| Jane Doe | | Wife | | 123 Main St | | Baltimore | | MD | | 21201 | | Jan 16, 1957 | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

RECEIVED
JUL 1 1957
BUREAU V. S.

6454

CERTIFICATE OF DEATH

06536

Reg. Dist. No. 223

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Sanitorium</u> | | d. STREET ADDRESS <u>11016 New Hampshire Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>FLORENCE</u> First <u>NEUMANN</u> Middle <u>NEUMANN</u> Last | | 4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 8, 1889</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U. S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>MAY Rosebaum</u> | | 14. MOTHER'S MAIDEN NAME <u>Lend Gundersheim</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Milton Neumann</u> | | Address <u>11016 N.H. Ave Silver Spring</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, left middle cerebral</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>332X</u> (b) <u>Diabetes mellitus</u> DUE TO (c) <u>30 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal insufficiency; Coronary atherosclerosis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>January</u> , 19 <u>57</u> , to <u>June 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>57</u> , and that death occurred at <u>7:24 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Norman H. Rubenstein</u> | | M.D. <u>6480 New Hampshire Ave.</u> <u>6/11/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Takoma PARK, Md.</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 22b. DATE THEREOF <u>6/14/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Wash., D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Wanzanovsky</u> | | ADDRESS <u>3501-14 St. N.W.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>6/13/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| | | | | | | | | | | | |
|------------------------------------|--|------------------------------------|--|------------------------------------|--|------------------------------------|--|------------------------------------|--|------------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | | <p>5. PLACE OF BIRTH</p> | | <p>6. OCCUPATION</p> | |
| <p>7. CAUSE OF DEATH</p> | | <p>8. MANNER OF DEATH</p> | | <p>9. PLACE OF DEATH</p> | | <p>10. DATE OF DEATH</p> | | <p>11. TIME OF DEATH</p> | | <p>12. SIGNATURE OF DECEASED</p> | |
| <p>13. SIGNATURE OF WITNESS</p> | | <p>14. SIGNATURE OF PHYSICIAN</p> | | <p>15. SIGNATURE OF CLERK</p> | | <p>16. SIGNATURE OF REGISTRAR</p> | | <p>17. SIGNATURE OF JUDGE</p> | | <p>18. SIGNATURE OF SHERIFF</p> | |
| <p>19. SIGNATURE OF CORONER</p> | | <p>20. SIGNATURE OF JURY</p> | | <p>21. SIGNATURE OF COURT</p> | | <p>22. SIGNATURE OF STATE</p> | | <p>23. SIGNATURE OF COUNTY</p> | | <p>24. SIGNATURE OF CITY</p> | |
| <p>25. SIGNATURE OF TOWN</p> | | <p>26. SIGNATURE OF WARD</p> | | <p>27. SIGNATURE OF BLOCK</p> | | <p>28. SIGNATURE OF LOT</p> | | <p>29. SIGNATURE OF HOUSE</p> | | <p>30. SIGNATURE OF STREET</p> | |
| <p>31. SIGNATURE OF AVENUE</p> | | <p>32. SIGNATURE OF BOULEVARD</p> | | <p>33. SIGNATURE OF PARKWAY</p> | | <p>34. SIGNATURE OF DRIVE</p> | | <p>35. SIGNATURE OF LANE</p> | | <p>36. SIGNATURE OF ROAD</p> | |
| <p>37. SIGNATURE OF HIGHWAY</p> | | <p>38. SIGNATURE OF TRAIL</p> | | <p>39. SIGNATURE OF PATH</p> | | <p>40. SIGNATURE OF ALLEY</p> | | <p>41. SIGNATURE OF COURT</p> | | <p>42. SIGNATURE OF YARD</p> | |
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| <p>475. SIGNATURE OF PARKWAY</p> | | <p>476. SIGNATURE OF DRIVE</p> | | | | | | | | | |

Reg. Dist. No.

DATE JUN 5 1957 J. Wilson Des

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

5 NOV 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

6557

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| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Virginia b. COUNTY Fairfax | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 20 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church 83x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 622 Whispering Lane | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Robert Middle (none) Last Nirenberg | | | | 4. DATE OF DEATH Month June Day 25 Year 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 6, 1910 | | 9. AGE (In years last birthday) 47 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Program Analyst | | | 10b. KIND OF BUSINESS OR INDUSTRY Government | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Louis Nirenberg | | | | 14. MOTHER'S MAIDEN NAME Sara Geldbart | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 530-07-9706 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable cardiac arrhythmias DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) rheumatic heart disease & mitral stenosis DUE TO (c) unknown causes | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes 5+ years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 5, 1957 to June 25, 1957 , that I last saw the deceased alive on June 25, 1957 , and that death occurred at 7:40 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Emery C. Herman, Jr. M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| DATE SIGNED 6/25/57 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| CREMATION | | JUNE 29 1957 | | CEDAR HILL CEMETERY | | SUITLAND MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home | | | | ADDRESS West D. Ave. | | 24. REC'D BY REGISTRAR JUN 27 1957 | |
| | | | | 25. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 27 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6558

CERTIFICATE OF DEATH

Reg. Dist. No.

06539

217

| | | | | | | | |
|---|--|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | c. LENGTH OF STAY IN 1b 17 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc. | | | | d. STREET ADDRESS Rt. #1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Louise Last O'Connell | | | | 4. DATE OF DEATH Month June Day 25 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Unknown | |
| 9. AGE (In years last birthday) yrs. 61 | | 10. IF UNDER 1 YEAR Months 6 Days 1 Hours 17 Min. | | 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Employee | | | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. A. | | 11. BIRTHPLACE (State or foreign country) Washington D. C. | |
| 13. FATHER'S NAME Jeffrey O'Connell | | | | 14. MOTHER'S MAIDEN NAME Eleanor Costello | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Hospital Record | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Generalized arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hr 5 hr 10 yr |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11500 | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 24, 1957 , to June 25, 1957 , that I last saw the deceased alive on June 24, 1957 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. D. Bonifant | | | | ADDRESS (Street, city or town, state) 6/25/57 | | | |
| PHYSICIAN'S NAME (Type) A. D. BONIFANT | | | | DATE SIGNED 6/25/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 28, 57 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gray W. Barber, Baytonsville, Md | | | | 24a. REC'D BY REGISTRAR 6/28/57 | | 24b. REGISTRAR'S SIGNATURE Barbara B. Lawler | |

715

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6559

CERTIFICATE OF DEATH

06540

Reg. Dist. No.

214

| | | | |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY 47x-3 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sanington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium | | d. STREET ADDRESS 3107 Cathedral Ave. N.W. | |
| 3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Peck | | 4. DATE OF DEATH Month June Day 23 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/16/66 |
| 9. AGE (In years last birthday) 91 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Rea Pattison | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Allen Peck Address 3107 Cathedral Ave. N.W. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) CHRONIC MYOCARDITIS | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 431X SENILITY | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY 28, 1954 , to 6-23, 1957 , that I last saw the deceased alive on JUNE 23, 1957 , and that death occurred at 6:10 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Henry M Lowdon M.D. 5206 Narbonne St. | | DATE SIGNED 6/23/57 | |
| PHYSICIAN'S NAME (Type) Henry M Lowdon | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 6/25/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington, D.C. | | 24a. REC'D BY REGISTRAR JUN 25 1957 24b. REGISTRAR'S SIGNATURE Frances Pottinger | |

BUREAU V. S.

JUN 25 1957

RECEIVED

6560

CERTIFICATE OF DEATH

06541

Reg. Dist. No.

216

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 10 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belmar 67X-3 | |
| 3. NAME OF DECEASED (Type or print) First Paula Middle Jean Marie Last Pezzella | | 4. DATE OF DEATH Month June Day 14 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 16, 1957 |
| 9. AGE (In years lost birthday) yrs. 3 Months 29 Days 29 Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Infant) | |
| 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Paul Pezzella | |
| 14. MOTHER'S MAIDEN NAME Faith Romano | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. 754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post op. Pulmonary Artery Constriction DUE TO (c) Congenital Heart Disease Ventricular Septal Defect INTERVAL BETWEEN ONSET AND DEATH 2 days 4 mo. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 4, 1957 , to June 14, 1957 , that I last saw the deceased alive on June 14, 1957 , and that death occurred at 3:10 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Clarence S. Weldon M.D. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| DATE SIGNED 6/14/57 | | 22. LOCATION (City, town, or county) (State) Monmouth County-New Jersey | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/17/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Catherine's | | 22d. LOCATION (City, town, or county) (State) Monmouth County-New Jersey | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 6-17-57 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 19 1957

BUREAU V. I.

6561

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 17 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital | | | | e. STREET ADDRESS Route #1 | | | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Martin Last PHELPS | | | | 4. DATE OF DEATH Month June Day 29 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 2, 1887 | |
| 9. AGE (In years lost birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | | | 10b. KIND OF BUSINESS OR INDUSTRY Commercial | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Andrew PHELPS | | | | 14. MOTHER'S MAIDEN NAME Annie MARTIN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I | | | | 16. SOCIAL SECURITY NO. 578-12-8048 | | 17. INFORMANT (Wife) MRS. Estella PHELPS (Same as #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerotic Cardiovascular disease | | | | INTERVAL BETWEEN ONSET AND DEATH Years. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12 June , 1957, to 29 June , 1957, that I last saw the deceased alive on 28 June , 1957, and that death occurred at 12:48 A.M. , from the causes and on the date stated above. 21 (R.M.) ADDRESS (Street, city or town, state) DATE SIGNED M.D. U.S. Naval Hospital, Bethesda, Md. 6-29-57 | | | | | | | |
| ACTUAL SIGNATURE Russell Miller, Jr. | | | | PHYSICIAN'S NAME (Type) RUSSELL MILLER, Jr., LT, MC, USN/U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1 July 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery | | 22d. LOCATION (City, town, or county) (State) Bealsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS R.A. Pumphrey, 7557 Wiso. Ave., Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 6-29-57 | |
| 24b. REGISTRAR'S SIGNATURE Mary B. Parrelly | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6456

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 223

06543

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakoma Park c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San and Hosp. | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY P.G. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphia d. STREET ADDRESS 3100 Bucklodge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John Adolph Plack | | 4. DATE OF DEATH 6/13/57 Month Day Year 19 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/18/37 Month Day Year 19 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nursery work | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 13. FATHER'S NAME Adolph H. Plack | | 14. MOTHER'S MAIDEN NAME Helen G. Boeck | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Helen Plack | | Address Same as # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive peritoneal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Rupture of the liver (c) Trauma to the abdomen DUE TO (c) Trauma to the abdomen | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dived about 30 ft and struck head on submerged rock | |
| 20c. TIME OF INJURY Month, Day, Year 5:45 AM 6/13/57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) creek | | 20f. (City or town) Silver Spring (County) Montg (State) MD. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 6/13/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 22b. DATE THEREOF June 15, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery | | 22d. LOCATION (City, town, or county) Prince George County, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters | | 24a. REC'D BY REGISTRAR J. Arthur Walters | |
| ADDRESS 254 Carroll St NW DC | | 24b. REGISTRAR'S SIGNATURE J. Arthur Walters | |
| DATE 6/15/57 | | DATE 6/15/57 | |

BUREAU V. S.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, Film 6217 7-5-57 et

Reg. Dist. No.

6562

065442/3

| | | | | | |
|---|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manor | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Off Md-R 355 1½ mi. W. Clarksburg | | | d. STREET ADDRESS Valley St., Box 157 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Henry Middle Andy Last Podgurski | | | 4. DATE OF DEATH Month 6 Day 22 Year 1957 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/4/20 | 9. AGE (In years last birthday) 37 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot, Commercial | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Penna | |
| 13. FATHER'S NAME Andy Podgurski | | | 14. MOTHER'S MAIDEN NAME Frances Phillips | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. 175-14-4480 | | 17. INFORMANT Capital Airline Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries, Extreme DUE TO (b) Body & Extremities badly Mutilated Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 861x | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Accident | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/22/57 19 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) country | |
| | | 20f. (City or town) Clarksburg Montg. Md. | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-26-57 | | 22c. NAME OF CEMETERY OR CREMATORY St Bonifac | |
| | | | | 22d. LOCATION (City, town, or county) Penn. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Miller Funeral Home. Manor. Pa. | | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE JUN 25 1957 | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 25 1957

BUREAU V. S.

| | |
|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| STATE OF NEW YORK | |
| COUNTY OF ALBANY | |
| CITY OF ALBANY | |
| DECEASED | |
| NAME | |
| AGE | |
| SEX | |
| RACE | |
| DATE OF DEATH | |
| PLACE OF DEATH | |
| CAUSE OF DEATH | |
| MANNER OF DEATH | |
| SIGNATURE OF MEDICAL EXAMINER | |
| DATE | |
| PLACE | |
| COUNTY | |
| STATE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6461

CERTIFICATE OF DEATH

06545

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville- | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Rest Home | | | | d. STREET ADDRESS 151 South Adams St. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) MARTHA First ANNA Middle POTTS Last | | | | 4. DATE OF DEATH June 17, 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JULY 31, 1872 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months 10 Days 16 Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Jessie N. Potts | | | | 14. MOTHER'S MAIDEN NAME Anna Cowman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Martha Burdette- Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gen'l Arteriosclerosis DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 16 June 57 20 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Congestive Heart Failure | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 17 June, 1957 to 17 June, 1957 , that I last saw the deceased alive on 17 June, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W.S. Murphy M.D. | | | | ADDRESS (Street, city or town, state) Rockville Maryland | | | |
| DATE SIGNED June 21 57 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/20/57 | | 22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery | | 22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR June 21 57 | |
| 24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey | | | | | | | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|----------------------------------|--|----------------------------------|--|
| NAME OF DECEASED M. Montgomery | | SEX Male | | AGE 100 | |
| DATE OF BIRTH October 1, 1857 | | PLACE OF BIRTH Maryland | | CITY OF BIRTH Baltimore | |
| DATE OF DEATH October 1, 1957 | | PLACE OF DEATH Home | | CITY OF DEATH Baltimore | |
| TIME OF DEATH 10:00 AM | | CAUSE OF DEATH Senility | | MANNER OF DEATH Natural | |
| DATE OF INTERMENT October 1, 1957 | | PLACE OF INTERMENT Home | | CITY OF INTERMENT Baltimore | |
| TIME OF INTERMENT 10:00 AM | | CAUSE OF INTERMENT Senility | | MANNER OF INTERMENT Natural | |
| DATE OF BURIAL October 1, 1957 | | PLACE OF BURIAL Home | | CITY OF BURIAL Baltimore | |
| TIME OF BURIAL 10:00 AM | | CAUSE OF BURIAL Senility | | MANNER OF BURIAL Natural | |
| DATE OF CREMATION October 1, 1957 | | PLACE OF CREMATION Home | | CITY OF CREMATION Baltimore | |
| TIME OF CREMATION 10:00 AM | | CAUSE OF CREMATION Senility | | MANNER OF CREMATION Natural | |
| DATE OF TRANSFER October 1, 1957 | | PLACE OF TRANSFER Home | | CITY OF TRANSFER Baltimore | |
| TIME OF TRANSFER 10:00 AM | | CAUSE OF TRANSFER Senility | | MANNER OF TRANSFER Natural | |
| DATE OF REINTERMENT October 1, 1957 | | PLACE OF REINTERMENT Home | | CITY OF REINTERMENT Baltimore | |
| TIME OF REINTERMENT 10:00 AM | | CAUSE OF REINTERMENT Senility | | MANNER OF REINTERMENT Natural | |
| DATE OF REBURIAL October 1, 1957 | | PLACE OF REBURIAL Home | | CITY OF REBURIAL Baltimore | |
| TIME OF REBURIAL 10:00 AM | | CAUSE OF REBURIAL Senility | | MANNER OF REBURIAL Natural | |
| DATE OF RECREMATION October 1, 1957 | | PLACE OF RECREMATION Home | | CITY OF RECREMATION Baltimore | |
| TIME OF RECREMATION 10:00 AM | | CAUSE OF RECREMATION Senility | | MANNER OF RECREMATION Natural | |
| DATE OF RETRANSFER October 1, 1957 | | PLACE OF RETRANSFER Home | | CITY OF RETRANSFER Baltimore | |
| TIME OF RETRANSFER 10:00 AM | | CAUSE OF RETRANSFER Senility | | MANNER OF RETRANSFER Natural | |
| DATE OF REINTERMENT October 1, 1957 | | PLACE OF REINTERMENT Home | | CITY OF REINTERMENT Baltimore | |
| TIME OF REINTERMENT 10:00 AM | | CAUSE OF REINTERMENT Senility | | MANNER OF REINTERMENT Natural | |
| DATE OF REBURIAL October 1, 1957 | | PLACE OF REBURIAL Home | | CITY OF REBURIAL Baltimore | |
| TIME OF REBURIAL 10:00 AM | | CAUSE OF REBURIAL Senility | | MANNER OF REBURIAL Natural | |
| DATE OF RECREMATION October 1, 1957 | | PLACE OF RECREMATION Home | | CITY OF RECREMATION Baltimore | |
| TIME OF RECREMATION 10:00 AM | | CAUSE OF RECREMATION Senility | | MANNER OF RECREMATION Natural | |
| DATE OF RETRANSFER October 1, 1957 | | PLACE OF RETRANSFER Home | | CITY OF RETRANSFER Baltimore | |
| TIME OF RETRANSFER 10:00 AM | | CAUSE OF RETRANSFER Senility | | MANNER OF RETRANSFER Natural | |

BUREAU V. 2

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6563

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06546

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital | | | | d. STREET ADDRESS 12019 Georgia Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First EDWARD Middle WOODROW Last PRATT | | 4. DATE OF DEATH Month June Day 9 Year 19 57 | | 5. SEX Male | | 6. COLOR OR RACE W | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH February 24, 1913 | | 9. AGE (In years last birthday) 44 yrs. | | IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min. 44 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper | | 10b. KIND OF BUSINESS OR INDUSTRY Landscaping | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Thomas Pratt | | | | 14. MOTHER'S MAIDEN NAME Mary Louise Turner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 578-10-0512 | | 17. INFORMANT Charles A. Pratt | | Address 12019 Georgia Avenue Silver Spring, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of the pons 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertention (c) 331X DUE TO (c) 331X | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4444X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported to have been in fight which had nothing to do with/ cause of death | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 1200 6 - 9 19 57 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) Silver Spring (County) Montgomery (State) Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M. D. | | DATE SIGNED 10 June 1957 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 12, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 22d. LOCATION (City, town, or county) Arlington (State) Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walter | | ADDRESS 254 Carroll Dr NW | | 24a. RECEIVED BY REGISTRAR JUN 11 1957 | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

JUN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6564

CERTIFICATE OF DEATH

06547

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wood Acres</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wood Acres</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5600 Harwick Road</u> | | d. STREET ADDRESS <u>5600 Harwick Road</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Sharpe Putnam</u> | | 4. DATE OF DEATH Month Day Year <u>June 2, 1957</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/14/1900</u> |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Greensboro, N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Jules Sharpe</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Donnell</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Clarence I. Sanders</u> | | Address <u>unknown</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Pulmonary Carcinoma</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Breast Carcinoma</u> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>3 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Cervical + Lumbar Spine Metastasis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 3, 1957</u> to <u>June 2, 1957</u> , that I last saw the deceased alive on <u>June 2, 1957</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda, Md.</u> DATE SIGNED <u>June 5 1957</u> | | | |
| ACTUAL SIGNATURE <u>D. J. Brennan</u> M.D. | | DATE SIGNED <u>June 5 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/4/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co, 2901 14th St. N.W.</u> | | 24a. REC'D BY REGISTRAR <u>June 5 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>d. H. Hedrick</u> | | | |



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

70-211

2000

RECEIVED
JUN 8 1964
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6565

CERTIFICATE OF DEATH

06548

Reg. Dist. No.

216

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 3827 Kansas Avenue, N. W. | |
| 3. NAME OF DECEASED (Type or print) First Della Middle Queen Last Rattley | | 4. DATE OF DEATH Month June Day 22 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH May 1, 1907 |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Tall Foster | | 14. MOTHER'S MAIDEN NAME Mattie Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT The Medical Record Address | | The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Malignant Lymphosarcoma - Mycosis Fungoides 4 yrs | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 519.2 Bilateral Pleural Effusions | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 8 , 19 57 , to June 22 , 19 57 , that I last saw the deceased alive on June 22 , 19 57 , and that death occurred at 11:22 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur J. Garceau M.D. | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/23/57 | |
| PHYSICIAN'S NAME (Type) ARTHUR J. GARCEAU, M. D. | | National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 6-26-57 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Carver | | 22d. LOCATION (City, town, or county) (State) Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jerns ADDRESS 1432 G St N W | | 24a. REC'D BY REGISTRAR DATE JUN 25 1957 | |
| 24b. REGISTRAR'S SIGNATURE Leslie Thompson | | | |

BUREAU V. S.

JUN 25 1957

RECEIVED

6566

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 7 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | d. STREET ADDRESS 9513 Milstead Drive | | | |
| 3. NAME OF DECEASED (Type or print) First Frances Middle Sensabaugh Last REAL | | | | 4. DATE OF DEATH Month June Day 3 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 11, 1934 | |
| 9. AGE (In years last birthday) 23 yrs. | | IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min. | | IF UNDER 24 HRS. Months 23 Days 23 Hours 23 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Oklahoma | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Leon SENSABAUGH | | | | 14. MOTHER'S MAIDEN NAME Mary GREER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Jack O. REAL (Husband) Address Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal pneumonia - bilateral 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHIAL ASTHMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FULL TERM 47-38 PREGNANCY DELIVERED 5/28/57 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 7 days 16 years | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20c. TIME OF INJURY Hour 19 Month, Day, Year p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 27 , 19 57 , to June 3 , 19 57 , that I last saw the deceased alive on June 3 , 19 57 , and that death occurred at 1055 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Harold I. Passes U.S. Naval Hospital, Bethesda, Md. 6-3-57 | | | | | | | |
| ACTUAL SIGNATURE Harold I. Passes M.D. U.S. Naval Hospital, Bethesda, Md. 6-3-57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Harold I. Passes, LT, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-8-57 | | 22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery | | 22d. LOCATION (City, town, or county) (State) Birmingham, Alabama | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 6-3-57 | | | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

| | | | | | | | |
|--|--|---|---|---------------|---|---|--|
| NAME OF DECEASED BENJAMIN (HARRIS) | | AGE 7 days | SEX Male | RACE Negro | DATE OF DEATH June 3, 1957 | PLACE OF DEATH St. Mary's Hospital, Baltimore, Md. | Cause of Death Sudden Infant Death Syndrome |
| MOTHER'S NAME Lillian Harrison | | FATHER'S NAME John O. Harris (Husband) | MOTHER'S RESIDENCE 1234 Elm Street, Baltimore, Md. | | FATHER'S RESIDENCE 1234 Elm Street, Baltimore, Md. | | DATE OF BIRTH June 3, 1957 |
| MOTHER'S OCCUPATION Homemaker | | FATHER'S OCCUPATION Unemployed | MOTHER'S EDUCATION High School Graduate | | FATHER'S EDUCATION High School Graduate | | DATE OF DEATH June 3, 1957 |
| MOTHER'S SIGNATURE Lillian Harrison | | FATHER'S SIGNATURE John O. Harris | MOTHER'S ADDRESS 1234 Elm Street, Baltimore, Md. | | FATHER'S ADDRESS 1234 Elm Street, Baltimore, Md. | | DATE OF DEATH June 3, 1957 |

BUREAU V. S.

JUN 5 1957

RECEIVED

| | | |
|--|---|---|
| DATE OF DEATH June 3, 1957 | PLACE OF DEATH St. Mary's Hospital, Baltimore, Md. | CAUSE OF DEATH Sudden Infant Death Syndrome |
| MOTHER'S NAME Lillian Harrison | FATHER'S NAME John O. Harris | MOTHER'S RESIDENCE 1234 Elm Street, Baltimore, Md. |
| MOTHER'S OCCUPATION Homemaker | FATHER'S OCCUPATION Unemployed | MOTHER'S EDUCATION High School Graduate |
| MOTHER'S SIGNATURE Lillian Harrison | FATHER'S SIGNATURE John O. Harris | MOTHER'S ADDRESS 1234 Elm Street, Baltimore, Md. |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JUN 24 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6568 CERTIFICATE OF DEATH

06551
Reg. Dist. No. 217

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 13 1/2 Hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. | | | | d. STREET ADDRESS 14600 Colesville Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Victoria Last Richardson | | 4. DATE OF DEATH Month June Day 15 Year 57 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/14/69 | 9. AGE (In years last birthday) 88 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Jacob V. Van Horn | | | | 14. MOTHER'S MAIDEN NAME Sarah E. Moore | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lula Edwards | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/11 , 19 57 , to 6/15 , 19 57 , that I last saw the deceased alive on 6/15 , 19 57 , and that death occurred at 2:30 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. W. Bird | | M.D. Sandy Sp | | ADDRESS (Street, city or town, state) Sandy Spring, Maryland | | DATE SIGNED 6/15/57 | |
| PHYSICIAN'S NAME (Type) J. W. Bird, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/18/57 | | 22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY | | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey | | | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE 6/17/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bentley B. Lawler | | | |

CERTIFICATE OF DEATH

1568

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED JOHN V. VAN BUREN | | 2. SEX Male | | 3. AGE 65 | |
| 4. DATE OF BIRTH 1892 | | 5. PLACE OF BIRTH NEW YORK | | 6. OCCUPATION None | |
| 7. MARITAL STATUS Married | | 8. COLOR White | | 9. ETHNIC ORIGIN None | |
| 10. PLACE OF DEATH Home | | 11. CAUSE OF DEATH Heart Disease | | 12. MANNER OF DEATH Natural | |
| 13. DATE OF DEATH June 21, 1957 | | 14. TIME OF DEATH 10:00 AM | | 15. SIGNATURE OF PHYSICIAN Dr. J. H. Smith | |
| 16. SIGNATURE OF REGISTRAR John V. Van Buren | | 17. SIGNATURE OF WITNESS Dr. J. H. Smith | | 18. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 19. SIGNATURE OF WITNESS Dr. J. H. Smith | | 20. SIGNATURE OF WITNESS Dr. J. H. Smith | | 21. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 22. SIGNATURE OF WITNESS Dr. J. H. Smith | | 23. SIGNATURE OF WITNESS Dr. J. H. Smith | | 24. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 25. SIGNATURE OF WITNESS Dr. J. H. Smith | | 26. SIGNATURE OF WITNESS Dr. J. H. Smith | | 27. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 28. SIGNATURE OF WITNESS Dr. J. H. Smith | | 29. SIGNATURE OF WITNESS Dr. J. H. Smith | | 30. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 31. SIGNATURE OF WITNESS Dr. J. H. Smith | | 32. SIGNATURE OF WITNESS Dr. J. H. Smith | | 33. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 34. SIGNATURE OF WITNESS Dr. J. H. Smith | | 35. SIGNATURE OF WITNESS Dr. J. H. Smith | | 36. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 37. SIGNATURE OF WITNESS Dr. J. H. Smith | | 38. SIGNATURE OF WITNESS Dr. J. H. Smith | | 39. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 40. SIGNATURE OF WITNESS Dr. J. H. Smith | | 41. SIGNATURE OF WITNESS Dr. J. H. Smith | | 42. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 43. SIGNATURE OF WITNESS Dr. J. H. Smith | | 44. SIGNATURE OF WITNESS Dr. J. H. Smith | | 45. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 46. SIGNATURE OF WITNESS Dr. J. H. Smith | | 47. SIGNATURE OF WITNESS Dr. J. H. Smith | | 48. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 49. SIGNATURE OF WITNESS Dr. J. H. Smith | | 50. SIGNATURE OF WITNESS Dr. J. H. Smith | | 51. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 52. SIGNATURE OF WITNESS Dr. J. H. Smith | | 53. SIGNATURE OF WITNESS Dr. J. H. Smith | | 54. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 55. SIGNATURE OF WITNESS Dr. J. H. Smith | | 56. SIGNATURE OF WITNESS Dr. J. H. Smith | | 57. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 58. SIGNATURE OF WITNESS Dr. J. H. Smith | | 59. SIGNATURE OF WITNESS Dr. J. H. Smith | | 60. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 61. SIGNATURE OF WITNESS Dr. J. H. Smith | | 62. SIGNATURE OF WITNESS Dr. J. H. Smith | | 63. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 64. SIGNATURE OF WITNESS Dr. J. H. Smith | | 65. SIGNATURE OF WITNESS Dr. J. H. Smith | | 66. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 67. SIGNATURE OF WITNESS Dr. J. H. Smith | | 68. SIGNATURE OF WITNESS Dr. J. H. Smith | | 69. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 70. SIGNATURE OF WITNESS Dr. J. H. Smith | | 71. SIGNATURE OF WITNESS Dr. J. H. Smith | | 72. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 73. SIGNATURE OF WITNESS Dr. J. H. Smith | | 74. SIGNATURE OF WITNESS Dr. J. H. Smith | | 75. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 76. SIGNATURE OF WITNESS Dr. J. H. Smith | | 77. SIGNATURE OF WITNESS Dr. J. H. Smith | | 78. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 79. SIGNATURE OF WITNESS Dr. J. H. Smith | | 80. SIGNATURE OF WITNESS Dr. J. H. Smith | | 81. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 82. SIGNATURE OF WITNESS Dr. J. H. Smith | | 83. SIGNATURE OF WITNESS Dr. J. H. Smith | | 84. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 85. SIGNATURE OF WITNESS Dr. J. H. Smith | | 86. SIGNATURE OF WITNESS Dr. J. H. Smith | | 87. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 88. SIGNATURE OF WITNESS Dr. J. H. Smith | | 89. SIGNATURE OF WITNESS Dr. J. H. Smith | | 90. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 91. SIGNATURE OF WITNESS Dr. J. H. Smith | | 92. SIGNATURE OF WITNESS Dr. J. H. Smith | | 93. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 94. SIGNATURE OF WITNESS Dr. J. H. Smith | | 95. SIGNATURE OF WITNESS Dr. J. H. Smith | | 96. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 97. SIGNATURE OF WITNESS Dr. J. H. Smith | | 98. SIGNATURE OF WITNESS Dr. J. H. Smith | | 99. SIGNATURE OF WITNESS Dr. J. H. Smith | |
| 100. SIGNATURE OF WITNESS Dr. J. H. Smith | | 101. SIGNATURE OF WITNESS Dr. J. H. Smith | | 102. SIGNATURE OF WITNESS Dr. J. H. Smith | |

BUREAU V. 8.

JUN 21 1957

RECEIVED

6/21/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6569

CERTIFICATE OF DEATH

06552 214

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs | | c. LENGTH OF STAY IN 1b 1 Week | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens rest Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1615.2 | |
| 3. NAME OF DECEASED (Type or print) First Lena Middle Last Richter | | 4. DATE OF DEATH Month June Day 23 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 1, 1882 |
| 9. AGE (In years last birthday) yrs. 75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unk. Schenck | | 14. MOTHER'S MAIDEN NAME Unk. Dora | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Dorothea Damm | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c) — | | | INTERVAL BETWEEN ONSET AND DEATH 146. years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.3 | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Nov. 27 , 19 14 , to June 23 , 19 57 , that I last saw the deceased alive on June 22 , 19 57 , and that death occurred at — M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Ronald S. Fleischer | | ADDRESS (Street, city or town, state) 5432 QUEENS CHAPEL Rd Hyattsville Md | |
| PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER | | DATE SIGNED 6/24/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 26, 1957 | 22c. NAME OF CEMETERY OR CREMATORY George Washington | 22d. LOCATION (City, town, or county) (State) Hyattsville Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | 24. REC'D BY REGISTRAR June 28 1957 | |
| ADDRESS Hyattsville, Md. | | 24b. REGISTRAR'S SIGNATURE Francis Patter | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------|--|-------------|--|-------------|--|-------------|--|------------------|--|----------------|--|-----------------|--|----------------|--|------------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| Silver Spring | | 1 Week | | Male | | White | | November 1, 1888 | | Germany | | Germany | | Diphtheria | | November 1, 1957 | | 10:30 AM | | Home | | J. H. [Signature] | | [Signature] | |
| 2721 Nicholson St. | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

JUN 28 1957

RECEIVED

6570

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. | | d. STREET ADDRESS Glenelg 13X12 | |
| 3. NAME OF DECEASED (Type or print) First George Middle Washington Last Ridgely | | 4. DATE OF DEATH Month June Day 22 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-23-1889 |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Ridgely | | 14. MOTHER'S MAIDEN NAME Ruth Day | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 1 | |
| 17. INFORMANT Hospital Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) toxic myocarditis DUE TO (c) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 8 hours 2 weeks 2 weeks | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 431X | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 21, 1957 , to June 22, 1957 , that I last saw the deceased alive on June 22, 1957 , and that death occurred at 11:40 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksburg, Md. DATE SIGNED 6/22/57 | | | |
| ACTUAL SIGNATURE Charles S. Whitaker M.D. | | DATE SIGNED 6/22/57 | |
| PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D. | | Village Clarksburg, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF 6/25/57 | 22c. NAME OF CEMETERY OR CREMATORY Mt. View | 22d. LOCATION (City, town, or county) (State) Alpha, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham | | 24a. REC'D BY REGISTRAR JUN 25 1957 | |
| ADDRESS Ellicott City, Md. | | 24b. REGISTRAR'S SIGNATURE Gertrude Lawley | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

JUN 25 1957

RECEIVED

| | | | |
|---|--|---|--|
| NAME OF DECEASED LAST, FIRST, MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH | | MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED | |
| OCCUPATION TRADE PROFESSION SERVICE | | PLACE OF DEATH HOME HOSPITAL OTHER | |
| CAUSE OF DEATH (To be filled in by physician or coroner) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) | | MANNER OF DEATH NATURAL ACCIDENT SUICIDE HOMICIDE UNDETERMINED | |
| SIGNATURE OF PHYSICIAN OR CORONER (To be filled in by physician or coroner) | | SIGNATURE OF REGISTRAR (To be filled in by registrar) | |
| DATE OF DEATH (To be filled in by registrar) | | PLACE OF DEATH (To be filled in by registrar) | |
| NAME OF CLERK FOR CERTIFICATE (To be filled in by registrar) | | SIGNATURE OF CLERK FOR CERTIFICATE (To be filled in by registrar) | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6571

CERTIFICATE OF DEATH

06554

Reg. Dist. No. 216

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN 1b <u>3 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 16. 15X-1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ROMULVS</u> Middle <u>ROD</u> Last <u>MAN</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-12-1873</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>PEARSON RODMAN</u> | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE (NOT KNOWN)</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>RUSSELL RODMAN - SON</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Infarction and</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>extensive Bronchopneumonia</u> DUE TO (c) <u>primary Carcinoma of lung.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>465X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 12, 1957</u> to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 12, 1957</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>DeWitt E. DeLawter</u> M.D. | | ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD Bethesda 14, MARYLAND</u> | |
| PHYSICIAN'S NAME (Type) <u>DeWITT E. DeLawter, M.D.</u> | | DATE SIGNED <u>6/12/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/15/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bladensburg R.d Washington D</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>6-14-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

| | | | |
|---|--|-----------------------------------|--------------------------------|
| NAME OF DECEASED JAMES EARL RAY | | DATE OF BIRTH 12-1-28 | PLACE OF BIRTH MOBILE, ALA. |
| SEX MALE | | AGE 28 | EDUCATION HIGH SCHOOL |
| OCCUPATION SALES | | MARRIAGE MAY 1956 | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | |
| DATE OF DEATH 4-4-68 | | PLACE OF DEATH MEMPHIS, TENN. | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | |
| SIGNATURE OF MINISTER | | SIGNATURE OF BURIAL OFFICIAL | |
| SIGNATURE OF FUNERAL HOME | | SIGNATURE OF COUNTY CLERK | |
| SIGNATURE OF STATE DEPARTMENT OF HEALTH | | SIGNATURE OF BALTIMORE CITY CLERK | |

RECEIVED
JUN 17 1957
BUREAU V. S.

6572

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|-------------------------|---|----------------------------------|
| 1. PLACE OF DEATH: Montgomery COUNTY MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Bethesda HOSPITAL OR INSTITUTION OR STREET ADDRESS 4913 Bayard Boulevard | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda STREET ADDRESS (If rural give location) 4913 Bayard Boulevard | |
| 3. NAME OF DECEASED: (Type or Print) Harriet L. Runbeck | | 4. DATE (Month) (Day) (Year) OF DEATH: June 19 1957 | |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH: 2/9/1883 |
| 9. AGE last birthday 74 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 10 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY: own home | |
| 11. BIRTHPLACE (State or foreign country): Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME: Unknown | | 14. MOTHER'S MAIDEN NAME: Unknown Farish | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT & ADDRESS: Merl Sliter--address unknown | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 570.4 IMMEDIATE CAUSE (A) Pneumonia | | | 36 hrs. |
| ANTECEDENT CAUSE (B) ileostomy 2° intestinal obstruction (pos perforative) | | | 5 wks. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | intestinal obstruction due to gall stone. | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) M. | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from May 5, 1957, to June 19, 1957, that I last saw the deceased alive on June 18, 1957, and that death occurred at 6:10 P M, from the causes and on the date stated above. | | | |
| SIGNATURE J. M. Thompson | | DATE SIGNED 19 June 57 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 6/22/57 | |
| NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | LOCATION (City, town, or county) Suitland, Maryland | |
| DATE REC'D BY LOCAL REGISTRAR 6-24-57 | | REGISTRAR'S SIGNATURE Benie M. Thompson | |
| 24. FUNERAL DIRECTOR | | ADDRESS Robert A. Pumphrey, Bethesda, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 27 1957

RECEIVED

6573

CERTIFICATE OF DEATH

06556

Reg. Dist. No.

215

| | | | | | | | |
|---|--|-------------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN TB 12 hours | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | | | |
| 3. NAME OF DECEASED (Type or print) First Willie Middle (nmn) Last RUSH | | | | 4. DATE OF DEATH Month June Day 10 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 9, 1957 | |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Days | | Hours Min. 11 35 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Willie Lee RUSH | | | | 14. MOTHER'S MAIDEN NAME Juanita L. DEAN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Father, Willie Lee RUSH (Same as #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 26-28 WEEKS 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GESTATION. DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 Hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from June 9, 1957 , to June 10, 1957 , that I last saw the deceased alive on June 10, 1957 , and that death occurred at 2:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Daniel Shuptar | | | | M.D. U.S. Naval Hospital, Bethesda, Md. 6-11-57 | | | |
| PHYSICIAN'S NAME (Type) Daniel SHUPTAR, LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6-12-57 | | 22c. NAME OF CEMETERY OR CREMATORY U.S. Naval Medical School | | 22d. LOCATION (City, town, or county) (State) Bethesda 14, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Naval Medical School, NMMC, Bethesda, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 6-12-57 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051192XVO

• • • • •

568

W. A. BURMAN

JUN 14 1957

RECEIVED

6457

CERTIFICATE OF DEATH

06557

Reg. Dist. No.

273

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Mont</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | | c. LENGTH OF STAY IN 1b <i>29 days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sen Hosp</i> | | | | e. STREET ADDRESS <i>15303 Glenwood Rd</i> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>Effie</i> Last <i>Rusk</i> | | | | 4. DATE OF DEATH Month <i>June</i> Day <i>22</i> Year <i>1957</i> | | | |
| 5. SEX <i>Fe</i> | | 6. COLOR OR RACE <i>Cauc</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>6/10/72</i> | |
| 9. AGE (In years last birthday) <i>55</i> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Ill</i> | | 11. BIRTHPLACE (State or foreign country) <i>USA</i> | |
| 13. FATHER'S NAME <i>Hammerbocker</i> | | | | 14. MOTHER'S MAIDEN NAME <i>—</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Hosp Records</i> | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral atherosclerosis + old thrombosis</i> DUE TO (c) <i>Hypertension</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i> <i>3 month</i> <i>7</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>446x</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 14</i> , 19 <i>57</i> , to <i>June 22</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/21</i> , 19 <i>57</i> , and that death occurred at <i>7:40 AM</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Chas H Wolohan</i> | | | | DATE SIGNED <i>6/24/57</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Chas H Wolohan</i> | | | | ADDRESS (Street, city or town, state) <i>Wash. DC</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL, SPECIFY <i>6/25/57</i> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <i>Wash. Nat. Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.</i> | | | | ADDRESS <i>Wash, D.C.</i> | | 24a. REC'D BY REGISTRAR <i>JUN 24 1957</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>J. Wilson</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is partially filled out with handwritten text.

BUREAU V. S.

JUN 24 1957

RECEIVED

6574

06558

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 17 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital | | | | d. STREET ADDRESS 2209 40th Street, N.W. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Joseph Last RYAN | | | | 4. DATE OF DEATH Month June Day 20 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 3, 1904 | |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME William Bernard RYAN | | | | 14. MOTHER'S MAIDEN NAME Leelinau LUTON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | (If yes, give war or dates of service) WW II | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT (Sister) Mrs. Leelinau MC DONALD (Same as #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal Varices 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of Liver DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH Immediate unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from June 3, 1957 , to June 20, 1957 , that I last saw the deceased alive on June 20, 1957 , and that death occurred at 9:45 AM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE Henry B. Karpinski | | | | M.D. U.S. Naval Hospital, Bethesda, Md. 6-20-57 | | | |
| PHYSICIAN'S NAME (Type) Henry B. KARPINSKI, LT MC USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-24-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines | | | | ADDRESS 2901 14th St., N.W. Washington, D.C. | | 24a. REC'D BY REGISTRAR 6-20-57 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Savelly | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6575

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>47x-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pensilvania</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u> | | d. STREET ADDRESS <u>2319 King Place N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>J</u> Last <u>SAUNDERS</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>19 57</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 9 1873</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OHIO</u> | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>DEXTER DRAKE</u> | | 14. MOTHER'S MAIDEN NAME <u>JULIETT SANDERSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>DR. C. K. SAUNDERS</u> | | Address <u>2319 KING PLACE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic HEART DISEASE</u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH. <u>2 YRS</u> <u>2 YRS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>55</u> , to <u>JUNE 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 22</u> , 19 <u>57</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>6/25/57</u> | | | |
| ACTUAL SIGNATURE <u>William T. Saccardi</u> M.D. | | 123 | |
| PHYSICIAN'S NAME (Type) <u>WILLIAM T SACCARDI</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 22b. DATE THEREOF <u>6/25/57</u> | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) <u>Cleveland, Ohio</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Nines Company,</u> | | 24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED JAMES V. S. | | 2. SEX Male | |
| 3. AGE 31 | | 4. RACE White | |
| 5. DATE OF DEATH JUN 27 1957 | | 6. PLACE OF DEATH Home | |
| 7. CITY Baltimore | | 8. COUNTY Baltimore | |
| 9. STATE Maryland | | 10. ZIP CODE 21201 | |
| 11. OCCUPATION None | | 12. CAUSE OF DEATH Heart Disease | |
| 13. MANNER OF DEATH Natural | | 14. SIGNATURE OF PHYSICIAN [Signature] | |
| 15. SIGNATURE OF REGISTRAR [Signature] | | 16. SIGNATURE OF WITNESS [Signature] | |

RECEIVED
JUN 27 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6576

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG217 7-11-57 et

CERTIFICATE OF DEATH

06560

Reg. Dist. No. 216

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D. C.</u> b. COUNTY <u>47X-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u> | | d. STREET ADDRESS <u>1115-12th St., N. W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Sherlock</u> Last <u>Sherlock</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 14, 1869</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Sherlock</u> | | 14. MOTHER'S MAIDEN NAME <u>Belle Seymour</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Miss Mildred Pope</u> | |
| 17. INFORMANT <u>Miss Mildred Pope</u> | | Address <u>926 Mass. Avenue N.W.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>10+ years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Summer, 1954</u> , to <u>June 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>57</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Alban Eger</u> M.D. | | ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> | |
| DATE SIGNED <u>June 26, 1957</u> | | DATE SIGNED <u>June 27, 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>Alban W. Eger</u> | | ADDRESS <u>1801 Eye Street, N.W.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>June 26-1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>J. W. Lee's Sons Co.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons Co - 300-4th St. N.E.</u> | | 24a. REC'D BY REGISTRAR <u>Beattie M. Thompson</u> | |
| ADDRESS <u>300-4th St. N.E.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

JUL 1 1957

RECEIVED

6577

CERTIFICATE OF DEATH

Reg. Dist. No.

213

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9800 Great Falls Road d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural- Rockville | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Rockville x2 d. STREET ADDRESS 9800 Great Falls Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mattie Elizabeth SHORB | | 4. DATE OF DEATH Month June Day 21 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 8, 1871 |
| 9. AGE (In years last birthday) 86 | | IF UNDER 1 YEAR: Months 0 Days 13 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Hamilton R. Geisbert | | 14. MOTHER'S MAIDEN NAME Martha R. Ramsburg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Glenn W. Shorb-Same Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinoma of rectum DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 m 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 1, 1956 to 6/21/1957 , that I last saw the deceased alive on 6/21/1957 , and that death occurred at 3:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stephen N. Jones M.D. | | ADDRESS (Street, city or town, state) Rockville Md DATE SIGNED 6/22/57 | |
| PHYSICIAN'S NAME (Type) Stephen N. Jones, M.D. | | Rockville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/24/1957 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wisconsin Avenue Bethesda, Maryland | | 24a. REC'D BY REGISTRAR JUN 24 1957 | 24b. REGISTRAR'S SIGNATURE Lawell H. Hester |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|--------------------------|--|
| Name of Deceased | | Date of Death | |
| John W. Smith | | June 8, 1957 | |
| Age | | Sex | |
| 65 | | Male | |
| Married | | Usual Residence | |
| Yes | | Baltimore, Md. | |
| Cause of Death | | Place of Death | |
| Heart Disease | | Home | |
| Immediate Cause | | Underlying Cause | |
| Myocardial Infarction | | Coronary Atherosclerosis | |
| Manner of Death | | Occupation | |
| Natural | | Retired | |
| Signature of Physician | | Signature of Registrar | |
| [Signature] | | [Signature] | |

RECEIVED
JUN 24 1957
BUREAU V. S.

6462

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. LENGTH OF STAY IN 1b 26 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 718 E. Montgomery Ave. | | d. STREET ADDRESS 1718 E. Montgomery Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) XXX First ELLA Middle SIMMONS Last SIMMONS | | 4. DATE OF DEATH June 30, 1957 Day 19 Year 19 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 19, 1873 |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months 8 Days 11 | IF UNDER 24 HRS. Hours 11 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Bennett Cooper | | 14. MOTHER'S MAIDEN NAME Nancy Barnes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Dennis C Simmons-Item # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction (c) Arterio-sclerotic C-V Disease | | INTERVAL BETWEEN ONSET AND DEATH 5 min 1 hr Indefinite | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 586x Chronic gall-bladder disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 12, 1956 , to June 30, 1957 , that I last saw the deceased alive on June 30, 1957 , and that death occurred at 3:20 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stephen N. Jones M.D. | | ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 6/30/57 | |
| PHYSICIAN'S NAME (Type) Stephen N. Jones-Rockville, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/2/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Walker Farm Cemetery | | 22d. LOCATION (City, town, or county) (State) Tyrrell County, N. Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR 7/2/57 24b. REGISTRAR'S SIGNATURE Laurell Kragtop | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|------------------------------|--|-----------------------|--|-------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | |
| J. J. Jones | | Male | | 45 | |
| RESIDENCE | | DATE OF DEATH | | PLACE OF DEATH | |
| 123 Main St., Baltimore, Md. | | Jan 15, 1957 | | Home | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF BURIAL | |
| Heart Disease | | Natural | | Jan 18, 1957 | |
| Physician's Signature | | Burial Place | | Burial Date | |
| J. J. Jones, M.D. | | St. Mary's Cemetery | | Jan 18, 1957 | |
| Signature of Registrar | | Signature of Minister | | Signature of Undertaker | |
| J. J. Jones | | J. J. Jones | | J. J. Jones | |

BUREAU V. 8

JUL 5 1957

RECEIVED

| | | | | | |
|-----------------------|--|---------------------|--|----------------|--|
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF BURIAL | |
| Jan 15, 1957 | | Home | | Jan 18, 1957 | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF BURIAL | |
| Heart Disease | | Natural | | Jan 18, 1957 | |
| Physician's Signature | | Burial Place | | Burial Date | |
| J. J. Jones, M.D. | | St. Mary's Cemetery | | Jan 18, 1957 | |

6578

CERTIFICATE OF DEATH

Reg. Dist. No. 216

06563

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Grant</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gormanian 85X-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u> | | | | d. STREET ADDRESS <u>Route 1, Box 98</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Dailey</u> Last <u>Simmons</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 9, 1902</u> | | 9. AGE (In years last birthday) <u>54</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u> | | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel Simmons</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cora Pifer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-10-7991</u> | | 17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of floor of mouth, metastatic</u> <u>143X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophageal vein compression</u> DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Septicemia</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>December 27, 19 56</u> , to <u>June 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>57</u> , and that death occurred at <u>6:15 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Peter D. Olch, M.D.</u> <u>The Clinical Center</u> <u>6/16/57</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | | |
| 22b. DATE THEREOF <u>6/18/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter F. Bickelmann</u> | | | | ADDRESS <u>3034 M St., N.W. Wash., D.C.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |
| 24a. REC'D BY REGISTRAR <u>6-18-57</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6579

CERTIFICATE OF DEATH

06564

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Rockville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural, Rockville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beall Mountain, Rockville, Md. | | | | d. STREET ADDRESS Beall Mountain | | | |
| 3. NAME OF DECEASED (Type or print) First Lyndon Middle F Last Small | | | | 4. DATE OF DEATH Month 6 Day 15 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/16/1897 | | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR Months 9 Days 29 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHD-Scientist | | 10b. KIND OF BUSINESS OR INDUSTRY Research | | 11. BIRTHPLACE (State or foreign country) Massachusetts | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frederick E. Samll | | | | 14. MOTHER'S MAIDEN NAME Amanda Cary | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. WW 1 | | 17. INFORMANT Mrs. M. C. Small | | Address item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of esophagus with DUE TO metastases to pleural cavity (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Dec 26, 1956 8 June 16, 1957 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May , 19 57 , to death , 19 , that I last saw the deceased alive on 6/13 , 19 57 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Lyndon F. Lee Jr. M.D. | | | | U.S. Veterans Admin - Washington 25, DC. | | | |
| PHYSICIAN'S NAME (Type) Lyndon F. Lee Jr. M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 6/17/57 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR 6/19/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Laurel Kragtorp | | fil E.C. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| NAME OF DECEASED [Faint text, possibly "John Doe"] | | SEX [Faint text, possibly "Male"] | |
| AGE [Faint text, possibly "45"] | | DATE OF BIRTH [Faint text, possibly "1912"] | |
| PLACE OF BIRTH [Faint text, possibly "Boston, Mass."] | | OCCUPATION [Faint text, possibly "Teacher"] | |
| CAUSE OF DEATH [Faint text, possibly "Heart Disease"] | | MANNER OF DEATH [Faint text, possibly "Natural"] | |
| DATE OF DEATH [Faint text, possibly "June 15, 1957"] | | TIME OF DEATH [Faint text, possibly "10:30 AM"] | |
| PLACE OF DEATH [Faint text, possibly "Home"] | | SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. John Smith"] | |
| SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"] | | SIGNATURE OF WITNESS [Faint text, possibly "John Doe"] | |

BUREAU V. B.

JUN 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6580

06565

CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Takoma Park</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D. C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> | | c. LENGTH OF STAY IN 1b <u>16 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>90 Oak House Hospital</u> | | e. STREET ADDRESS <u>517 Albany Ave. Wash</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>L</u> Last <u>Smith</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 25, 1888</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Syracuse, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.B.</u> | |
| 13. FATHER'S NAME <u>John Markert</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>John C. Smith</u> | | Address <u>3480</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension + gen. arteriosclerosis</u> DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>7 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 1, 1957</u> to <u>June 25, 1957</u> that I last saw the deceased alive on <u>6/25, 1957</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>D.B. Washington</u> M.D. | | ADDRESS (Street, city or town, state) <u>6234 3rd Ave N.W. Wash D.C. 6/25/57</u> | |
| PHYSICIAN'S NAME (Type) <u>D.B. Washington MD</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/29/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Syracuse N.Y.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.K. Huntman & Son</u> | | 24a. REC'D BY REGISTRAR <u>6/28/57</u> 24b. REGISTRAR'S SIGNATURE <u>J. H. Huntman</u> | |
| ADDRESS <u>5732 Sa Ave N.W.</u> | | | |

CERTIFICATE OF DEATH

Form with multiple sections for death certificate information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

1. NAME OF DECEASED: *John Doe*

2. DATE OF DEATH: *July 1, 1957*

3. PLACE OF DEATH: *Home*

4. CAUSE OF DEATH: *Heart Disease*

5. PLACE OF BIRTH: *Baltimore, Md.*

6. DATE OF BIRTH: *July 1, 1900*

7. SEX: *Male*

8. RACE: *White*

9. OCCUPATION: *Teacher*

10. MARITAL STATUS: *Married*

11. SIGNATURE OF DECEASED: *[Signature]*

12. SIGNATURE OF WITNESSES: *[Signatures]*

13. SIGNATURE OF PHYSICIAN: *[Signature]*

14. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. 1

JUL 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6581

06566

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XIKENSINGTON</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>PAMELA</u> Middle <u>LEE</u> Last <u>SORRELL</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>8</u> Year <u>1957</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-2-1957</u> |
| 9. AGE (In years last birthday) yrs. <u>6</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>FRED SORRELL</u> | | 14. MOTHER'S MAIDEN NAME <u>GRACE WILSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>FRED SORRELL</u> | | Address <u>10905 DRUMM AVE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (6½ months gestation)</u> 6 days (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>JUNE 2</u> , 19 <u>57</u> , to <u>JUNE 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 8</u> , 19 <u>57</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Sydney Ross M.D.</u> M.D. | | ADDRESS (Street, city or town, state) <u>5415 Conn. Ave. NW. Wash. D.C.</u> | |
| PHYSICIAN'S NAME (Type) <u>Sydney Ross M.D.</u> | | DATE SIGNED <u>6-11-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 22b. DATE THEREOF <u>6/10/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | 24a. REC'D BY REGISTRAR <u>Bessie M. Pumphrey</u> | |
| ADDRESS <u>Bethesda, Maryland</u> | | 24b. REGISTRAR'S SIGNATURE | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6582

CERTIFICATE OF DEATH

06567

Reg. Dist. No.

216

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | c. LENGTH OF STAY in 1b Chevy Chase x 2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4319 Center Street | | d. STREET ADDRESS 4319 Center Street | |
| 3. NAME OF DECEASED (Type or print) First M. Middle ROSALIE Last SPROW | | 4. DATE OF DEATH Month June Day 27 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/6/1903 |
| 9. AGE (In years last birthday) 53 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietician | | 10b. KIND OF BUSINESS OR INDUSTRY Leopold, Indiana | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Peter Solbrig | | 14. MOTHER'S MAIDEN NAME Katherine Goffinet | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 308-24-7199 | |
| 17. INFORMANT Evelyn Richardson, (Same as # 2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of Liver DUE TO (c) Hepatitis INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 yrs ? 2 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1, 1955 , to 6/27, 1957 , that I last saw the deceased alive on 6/26/57 , 19____, and that death occurred at 2:45 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. B. Sims | | M.D. 1150 Connecticut Ave DATE SIGNED 6/27/57 | |
| PHYSICIAN'S NAME (Type) W. B. SIMS, M.D. | | Washington D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/29/57 | 22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawler's Sons | | ADDRESS 1756 Pa. Ave., N.W. DC | |
| 24a. REC'D BY REGISTRAR DATE 6-27-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------|--|---------------------|--|
| NAME OF DECEASED MONTGOMERY | | MONTGOMERY | |
| GIVEN NAME JERRY CHASE | | JERRY CHASE | |
| AGE 42 | | 42 | |
| SEX Male | | Male | |
| DATE OF BIRTH June 27, 1915 | | June 27, 1915 | |
| PLACE OF BIRTH Baltimore, Maryland | | Baltimore, Maryland | |
| RACE White | | White | |
| RELIGION Catholic | | Catholic | |
| MARRIAGE Never Married | | Never Married | |
| EDUCATION High School | | High School | |
| OCCUPATION None | | None | |
| CAUSE OF DEATH Heart Disease | | Heart Disease | |
| MANNER OF DEATH Natural | | Natural | |
| DATE OF DEATH July 2, 1957 | | July 2, 1957 | |
| PLACE OF DEATH Home | | Home | |
| SIGNATURE OF DECEASED (None) | | (None) | |
| SIGNATURE OF WITNESSES (None) | | (None) | |
| SIGNATURE OF PHYSICIAN (None) | | (None) | |
| SIGNATURE OF CORONER (None) | | (None) | |
| SIGNATURE OF REGISTRAR (None) | | (None) | |

BUREAU V. 1

JUL 2 1957

RECEIVED

6458

CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. & Hospital</u> | | | | d. STREET ADDRESS <u>12416 Denley Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>James Leo Stapleton</u> | | | | 4. DATE OF DEATH <u>June 29 1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-5-89</u> | |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>Mr. James Stapleton</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Catherine Thompson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES WW #1</u> | | | | 16. SOCIAL SECURITY NO. <u>214-03-4072-A</u> | | | |
| 17. INFORMANT <u>Chart</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> | | | | | | | <u>2 wks.</u> |
| 540.0 DUE TO <u>MASSIVE BLEEDING FROM</u> | | | | | | | |
| (b) <u>GASTRIC ULCERS</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>SHOCK. POST-SUBTOTAL GASTRECTOMY</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>27 JUNE 1957</u> to <u>29 June 1957</u> that I last saw the deceased alive on <u>29 June 1957</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>1726 Eye NW, D.C.</u> DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>Frederick B. Brandt</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>FREDERICK B. BRANDT M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>7/3/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> | | | | ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>J. M. D. D. D.</u> | |
| | | | | DATE <u>7/2/57</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. B.

UL 3 1957

RECEIVED

6463

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Sanitarium | | d. STREET ADDRESS 3636 - 16th St., N. W. | |
| 3. NAME OF DECEASED (Type or print) First CLARA Middle N. Last STEINER | | 4. DATE OF DEATH Month June Day 14 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 25, 1890 |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 19 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't Retired | |
| 11. BIRTHPLACE (State or foreign country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Benjamin Weems | | 14. MOTHER'S MAIDEN NAME Mary Rutherford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Robert F. Steiner | | Address 5810 Wilmett Road Bethesda, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.1 DUE TO Arteriosclerosis & Thrombosis Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 48 Hours | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Myocardial infarction | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 1, 1957 to June 13, 1957 that I last saw the deceased alive on June 11, 1957 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 809 Viers Mill Rd. DATE SIGNED 6/14/57 | | | |
| ACTUAL SIGNATURE G. Bowditch Hunter, Jr. M.D. | | 809 Viers Mill Rd. | |
| PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr. | | Rockville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-18-57 | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | 22d. LOCATION (City, town, or county) (State) Arlington Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Humphrey | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR 6/17/57 | | 24b. REGISTRAR'S SIGNATURE Laurel Kragtop pub E.C. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | |
| Robert V. Sholner | | 39 | | Male | | White | | June 15, 1957 | | Baltimore, Maryland | |
| Usual Residence | | Date of Birth | | Married | | Occupation | | Cause of Death | | Manner of Death | |
| Baltimore, Maryland | | June 15, 1918 | | Yes | | None | | Myocardial Infarction | | Natural | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Informant | | Signature of Informant | | Signature of Informant | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. E.

JUN 18 1957

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| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>10305 Haywood Dr.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Stern</u> Last <u>Stern</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 3, 1898</u> | |
| 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Mandel Stern</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mollie Fine</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Hetty Stern</u> Address <u>10305 Haywood Dr.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ACUTE CORONARY OCCLUSION</u> DUE TO (c) <u>ARTERIOSCLEROTIC C.V.D.</u> 2 yrs | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr.</u> <u>2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>6-20</u> , 19 <u>57</u> , to <u>6-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-20</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Bernard H. Ostrow</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>7961 Eastern Ave., Sil. Spg., Md.</u> DATE SIGNED <u>6-20-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Bernard H. Ostrow</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>June 23, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Va.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danyansky & Sons</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>6/28/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

6584

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 2 weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp. | | | | d. STREET ADDRESS 1500 East West Highway | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Hanna Middle S Last Stewart | | | | 4. DATE OF DEATH Month June Day 29 , Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 29, 1894 | |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Calvin Saltzer | | | | 14. MOTHER'S MAIDEN NAME Emma Taylor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Harrison M. Stewart | | | | Address same as #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriolonephrosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5721.2, inoperable carcinoma with gastrointestinal hemorrhage | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Silver Spring, Maryland | | | | (County) (State) | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 29 June , 19 57 , and that death occurred at 10:25 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE L. Marshall Cuvillier | | | | ADDRESS (Street, city or town, state) 1407 WOODSIDE PARKWAY SILVER SPRING, MARYLAND | | | |
| PHYSICIAN'S NAME (Type) L. Marshall Cuvillier | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-2-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins | | | | ADDRESS 3821 14th St. N.W. Wash. D.C. | | 24a. REC'D BY REGISTRAR DATE 7-3-57 | |
| 24b. REGISTRAR'S SIGNATURE Bernie M. Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18

| | | | |
|-------------------|--|--------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| PLACE OF DEATH | | CITY OF DEATH | |
| OCCUPATION | | CAUSE OF DEATH | |
| MANNER OF DEATH | | MEDICAL ATTENDANT | |
| AGE | | SEX | |
| RACE | | RELIGION | |
| EDUCATION | | MARRIAGE | |
| BIRTH | | DEATH | |
| FATHER | | MOTHER | |
| SIBLINGS | | PREVIOUS MARRIAGES | |
| MILITARY SERVICE | | HISTORICAL RECORD | |
| VITAL RECORDS | | MARRIAGE RECORDS | |
| BIRTH RECORDS | | DEATH RECORDS | |
| MARRIAGE RECORDS | | DIVORCE RECORDS | |
| WILLS | | ESTATES | |
| FUNERAL RECORDS | | BURIAL RECORDS | |
| CREMATION RECORDS | | RECEIPTS | |
| CERTIFICATES | | NOTICES | |
| ANNOUNCEMENTS | | OBITUARIES | |
| EULOGIES | | SERMONS | |
| PRAYERS | | BENEDICTIONS | |
| CLOSING PRAYERS | | FINAL RITES | |
| FUNERAL HOME | | CITY OF DEATH | |
| STATE OF DEATH | | FEDERAL DEATH | |
| MARRIAGE RECORDS | | DIVORCE RECORDS | |
| WILLS | | ESTATES | |
| FUNERAL RECORDS | | BURIAL RECORDS | |
| CREMATION RECORDS | | RECEIPTS | |
| CERTIFICATES | | NOTICES | |
| ANNOUNCEMENTS | | OBITUARIES | |
| EULOGIES | | SERMONS | |
| PRAYERS | | BENEDICTIONS | |
| CLOSING PRAYERS | | FINAL RITES | |

BUREAU V. 3

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6585

CERTIFICATE OF DEATH

Reg. Dist. No. 06572 216

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>11 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | | | d. STREET ADDRESS <u>5311-LOANSTAVE</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse Cyrus Stoddard</u> | | | | 4. DATE OF DEATH Month Day Year <u>JUNE 27 1957</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 16 1886</u> 70 yrs. | |
| 9. AGE (In years last birthday) | | IF UNDER 1 YEAR Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Josiah Stoddard</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucy Wilson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>John C. Stoddard</u> Address <u>Bethesda 9514-Milstead Dr.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 422.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Bilateral confluent bronchopneumonia</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from <u>20 June, 1957</u> , to <u>27 June, 1957</u> , that I last saw the deceased alive on <u>27 June, 1957</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE <u>Verace W. Bernick</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Verace W. Bernick</u> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/28/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>6-30-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u> | | | | | | | |

BUREAU V. 8

1957 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

6536

CERTIFICATE OF DEATH

Reg. Dist. No.

06573

2/2

| | | | | | | | |
|---|----------------------------------|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DICKERSON | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL | | | | d. STREET ADDRESS ROUTE 2 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES FREDERICK STONE | | | | 4. DATE OF DEATH Month Day Year 6 7 19 57 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/5/76 | | 9. AGE (In years lost birthday) yrs. 80 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter - Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME GEORGE C. STONE | | | | 14. MOTHER'S MAIDEN NAME ELLEN N. FRALEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-03-6974 | | 17. INFORMANT ROBERT O. STONE 1445 1445 ODDEN ST. NW. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Cardio Vasc. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from June 1953 to 7 June 1957 , that I last saw the deceased alive on 3 June 1957 , and that death occurred at M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Gordon N. Smith | | | | ADDRESS (Street, city or town, state) Barnesville, Maryland | | | |
| DATE SIGNED 8 June 57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Gordon N. Smith | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/11/57 | | 22c. NAME OF CEMETERY OR CREMATORY Mt Zion | | 22d. LOCATION (City, town, or county) (State) Frederick Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton Barnesville, Md | | | | 24a. REC'D BY REGISTRAR DATE 6/10/57 | | 24b. REGISTRAR'S SIGNATURE Charles W. Elgin | |

CERTIFICATE OF DEATH

Arterio sclerotic cardiac disease. Approx 3 years

BUREAU V. I.

JUN 12 1957

RECEIVED

Barnesville, Maryland

John J. Barnes

June 23 1957

6537

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 6 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arlington | | 83X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 4773 24th Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First Virginia | | Middle Hodgson | | Last SUTLIFF | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 15, 1908 | |
| 9. AGE (In years last birthday) 49 | | IF UNDER 1 YEAR Months Days Hours Min. | | 4. DATE OF DEATH June 5 1957 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Frank B. HODGSON | | | | 14. MOTHER'S MAIDEN NAME Kathryn POWELL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) - - - | | 17. INFORMANT (Husband) Robert C. SUTLIFF (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Metastatic to Brain 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Anaplastic Carcinoma, Rt. Breast DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 mos - | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 30, 1957 , to June 5, 1957 , that I last saw the deceased alive on June 5, 1957 , and that death occurred at 3:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-5-57 | | | | | | | |
| ACTUAL SIGNATURE T.S. Dunn, Jr. | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | | | |
| PHYSICIAN'S NAME (Type) T.S. DUNN, JR., LT. MC, USN | | U.S. Naval Hospital, Bethesda, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-7-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons | | ADDRESS 1756 Penn. Ave., N.W. Wash.D.C. | | 24a. REC'D BY REGISTRAR DATE 6-5-57 | | 24b. REGISTRAR'S SIGNATURE Mary B. Pamel | |

JUN 6 1957

RECEIVED

6588

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glencove 62x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, write name of institution) The Clinical Center National Institutes of Health, Bethesda, Md. | | d. STREET ADDRESS (No street address) | |
| 3. NAME OF DECEASED (Type or print) First Nettie Middle Alice Last Steines | | 4. DATE OF DEATH Month June Day 8 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 26 April 1893 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR: Months 6 Days 4 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Mathis Lehmann | | 14. MOTHER'S MAIDEN NAME Amelia Huncke | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 203X DUE TO ARTERIAL SCLEROSIS, SEVERE, CASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA, LEFT LOWER LOBE (c) DAY 5 | | INTERVAL BETWEEN ONSET AND DEATH 8 Mo 5 Yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) * | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February 27, 1957 , to June 8, 1957 , that I last saw the deceased alive on June 8, 1957 , and that death occurred at 7:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Md. DATE SIGNED 6/9/57 | | | |
| ACTUAL SIGNATURE Gurston Goldin M.D. | | PHYSICIAN'S NAME (Type) Gurston Goldin, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 6-10-57 | | 22b. DATE THEREOF 6-10-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | | 22d. LOCATION (City, town, or county) (State) St. Louis County, Missouri | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR 6-11-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL CASE OF DEATH

BUREAU V. S.

JUN 12 1957

RECEIVED

6589

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 55 days | | | |
| d. NAME OF HOSPITAL (If name of hospital give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | e. STREET ADDRESS 108 Wythe Street | | | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle Hershelia Last Strange | | | | 4. DATE OF DEATH Month June Day 3 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 16 August 1909 | |
| 9. AGE (In years last birthday) 47 | | IF UNDER 1 YEAR Months 4 Days 1 Hours 15 Min. | | IF UNDER 24 HRS. Months 4 Days 1 Hours 15 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Henry Lyles | | | | 14. MOTHER'S MAIDEN NAME Harriet Dorsey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix uteri - direct extension to all pelvic organs & extensive metastases to all abdominal structures DUE TO (b) metastases to all abdominal structures DUE TO (c) metastases to all abdominal structures Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hydrothorax & small & large bowel obstruction | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour 19 Month, Day, Year p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Bethesda | | | | 20g. (County) Montgomery | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from April 2, 1957 , to June 3, 1957 , that I last saw the deceased alive on June 3, 1957 , and that death occurred at 5.00 P.M. , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | | | | | | |
| DATE SIGNED 6/5/57 | | | | | | | |
| ACTUAL SIGNATURE Chester Z. Haverback M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Chester Z. Haverback, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 6/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY Bethesda | | 22d. LOCATION (City, town, or county) (State) Alexandria Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arnold Thaw | | | | ADDRESS 311 1/2 Patrick St. | | 24a. REC'D BY REGISTRAR DATE 6/6/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

JUN 11 1957

RECEIVED

6590

CERTIFICATE OF DEATH

06577

Reg. Dist. No.

214

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>-</u> | | | | d. STREET ADDRESS <u>1704 Roeder St</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH K TAYLOR</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 15 1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 28 1868</u> | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>S. Mason</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Charlotte Gable</u> | | Address <u>704 Roeder St</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-23</u> , 19 <u>51</u> , to <u>6-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-14</u> , 19 <u>57</u> , and that death occurred at <u>10:57 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W.B. Wardrop</u> | | | | ADDRESS (Street, city or town, state) <u>837 Bonifant St. Silver Spring Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W.B. WARDROP</u> | | | | DATE SIGNED <u>6/15/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-17-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Switland Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> | | | | ADDRESS <u>4812 Ga Ave</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 20 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | | | |

BUREAU V. 3

JUN 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6591

CERTIFICATE OF DEATH

Reg. Dist. No.

06578 216

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN</u> | | d. STREET ADDRESS <u>4017 VANNESSE ST. NW.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>DWIGHT</u> Middle <u>KIGGINS</u> Last <u>TERRY</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 10-1898</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. POST OFFICE</u> | | 11. BIRTHPLACE (State or foreign country) <u>WASH. DC</u> | |
| 13. FATHER'S NAME <u>GEORGE E. TERRY</u> | | 14. MOTHER'S MAIDEN NAME <u>SARA KIGGINS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give year or dates of service) <u>1917-</u> | | 16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>MRS. HELEN TERRY (WIFE)</u> Address <u>4017 VANNESSE WASH. DC</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive cerebro-pontine hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>?</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>2 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>757.1</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | |
| 20c. TIME OF INJURY Hour a. m. <u>None</u> Month <u>None</u> Day <u>None</u> Year <u>None</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>present</u> , 19____, that I last saw the deceased alive on <u>6/14/57</u> , 19____, and that death occurred at <u>1259 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John B. Umhau</u> M.D. | | ADDRESS (Street, city or town, state) <u>8805 Conn. Ave Chevy Chase Md</u> | |
| DATE SIGNED <u>6/14/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAV</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL, SPECIFY <u>burial</u> | | 22b. DATE THEREOF <u>6/17/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 17 1957</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | |

BUREAU A

1957 27 134

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06579

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac river near Great Falls</u> | | | | d. STREET ADDRESS <u>2833-27th St., N. W.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>KELBY</u> Last <u>THOMAS</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 6, 1927</u> | |
| 9. AGE (In years last birthday) <u>29</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Horace Kelby Thomas</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ethel Lee Allison</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>Korean</u> | | 17. INFORMANT <u>William R. Thomas</u> | | Address <u>Same as Item #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia by Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drown while swimming in Potomac River</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>6:00</u> p. m. <u>6-17-57</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Item #1</u> | | 20f. (City or town) (County) (State) <u>Potomac</u> <u>Mtg.</u> <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. BROSCHART</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>June 23, 1957</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-25-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>DATE 6-24-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Russell M. Thompson</u> | | | |

MEDICAL CERTIFICATION

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15

2

[Faint, illegible handwritten notes at the bottom of the page]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06580

Reg. Dist. No.

213

6593

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac R. at Great Falls | | d. STREET ADDRESS Box 312 - Route 4 | |
| 3. NAME OF DECEASED (Type or print) First James Middle Howard Last Thomas | | 4. DATE OF DEATH Month June Day 23 , 19 39 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/23/1939 |
| 9. AGE (In years last birthday) 18 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman | | 10b. KIND OF BUSINESS OR INDUSTRY Telephone | 11. BIRTHPLACE (State or foreign country) N.C. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Wm. H. Thomas | |
| 14. MOTHER'S MAIDEN NAME Manda May | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. 223-50-5217 | | 17. INFORMANT John P. Thomas. Address Alexandria Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO Drowning Conditions, if any, which gave rise to immediate cause (b) (c) Sudden DUE TO Sudden (c) Sudden | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped from rock while wading in Pot. R. | |
| 20c. TIME OF INJURY Month, Day, Year 5:10 Hour XX p. m. 6/23/57 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Great Falls, Pot. R. Potomac Montg Md. | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 6/25/57 | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-28-57 | 22c. NAME OF CEMETERY OR CREMATORY Family Cemetery. | 22d. LOCATION (City, town, or county) (State) Trade Tenn. |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Demaine & Son. | | ADDRESS Alexandria Va. | |
| 24a. REC'D BY REGISTRAR JUN 28 1957 | | 24b. REGISTRAR'S SIGNATURE Samuel Krug | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 06581 | |
|---|--|----------------------------------|--|---|---|--|--|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. 213 | |
| Items 12, 13, 14, Film G217 7-11-57 et | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Off Md.R-355 1 1/2 mi. W. Clarksburg | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Ill. b. COUNTY 51X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn d. STREET ADDRESS 6637 W. 21st. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Kenneth Last Thomas | | | | | 4. DATE OF DEATH Month 6 Day 22 Year 57 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/26/27 | | 9. AGE (In years last birthday) 30 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-Pilot | | | | 10b. KIND OF BUSINESS OR INDUSTRY Air Lines | | 11. BIRTHPLACE (State or foreign country) Chicago, Illinois | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William Thomas | | | | | 14. MOTHER'S MAIDEN NAME Florence Johnson | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. 354-16-6432 | | 17. INFORMANT Capital Airline Records Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries, Extreme 861X DUE TO Body & Extremities badly Mutilated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Accident | | | | | | |
| 20c. TIME OF INJURY Hour 9:00 a. m. xx Month, Day, Year 6/22/57 | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) country | | 20f. (City or town) Clarksburg (County) Montg. Md. (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED 6/22/57 | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-26-57 | | 22c. NAME OF CEMETERY OR CREMATORY Milwaukee | | | 22d. LOCATION (City, town, or county) Milwaukee (State) Wiscon | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg. Md. | | | | | | 24a. REC'D BY REGISTRAR JUN 25 1957 | | 24b. REGISTRAR'S SIGNATURE Ernest C. Gartner | | | |

MAINE AND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. 3.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6595

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Kensington</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10410 Fawcett Street</u> | | d. STREET ADDRESS <u>10410 Fawcett Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>N.</u> Last <u>TRADER</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 27 1893</u> |
| 9. AGE (In years lost birthday) <u>63</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>27</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jacob P. Norlin</u> | | 14. MOTHER'S MAIDEN NAME <u>Jeanette Frost</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Mary F. Dyott-Easton, Maryland</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Papillary Carcinoma Left Breast</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>June 24</u> , 1957, that I last saw the deceased alive on <u>June 23</u> , 1957, and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Marion Bankhead</u> | | ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u> | |
| DATE SIGNED <u>6/24/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead Silver Spring, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u> | | 22b. DATE THEREOF <u>6/26/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>6-27-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

JUL 1 1957

RECEIVED

6596

CERTIFICATE OF DEATH

Reg. Dist. No. 2126

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Kensington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Kensington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4829 Flanders Ave (Garrett Park) | | d. STREET ADDRESS 4829 Flanders Ave. (Garrett Park) | |
| 3. NAME OF DECEASED (Type or print) WILLIAM PERRY TRAIL | | 4. DATE OF DEATH Month June Day 18 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 13, 1906 |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR Months 7 Days 5 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Wm. P. Trail | | 14. MOTHER'S MAIDEN NAME Alethia E. Poole | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs Mary N. Trail-Item # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY + H ROM BOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X CONGESTIVE HEART FAILURE | | | |
| INTERVAL BETWEEN ONSET AND DEATH ONE HOUR 15 YEARS 10 YEARS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JAN-10, 1957 , to JUNE 18, 1957 , that I last saw the deceased alive on JUNE 18, 1957 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gordon S. Rosenberger M.D. | | ADDRESS (Street, city or town, state) 26 N. SUMMIT AVE Gaithersburg, Md. | |
| PHYSICIAN'S NAME (Type) Gordon S. Rosenberger | | DATE SIGNED 19 June 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/22/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rockville Union | | 22d. LOCATION (City, town, or county) (State) Rockville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR 6-24-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 42 hours after death.

BUREAU V. 1

JUN 26 1957

RECEIVED

6597

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 61 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 833 New Hampshire Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Florence Middle Virginia Last Utermoehlen | | 4. DATE OF DEATH | | Month June Day 1 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 24, 1910 | 9. AGE (In years lost birthday) 46 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Variety Store | | 11. BIRTHPLACE (State or foreign country) Williams, W. VA. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Daniel G. Mumma | | | | 14. MOTHER'S MAIDEN NAME Theresa Zimmerley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577-05-2554 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma - left pleura - with 163X DUE TO massive pleural effusion & atelectasis - left lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bowel obstruction - 2° to adhesions DUE TO around ileum (c) etc. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sleeve cutaneous fecal fistula - to Rt lower Quadrant 2 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) + vaginitis | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 1 , 19 57 , to June 1 , 19 57 , that I last saw the deceased alive on June 1 , 19 57 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Chester Z. Haverback M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center | | DATE SIGNED 6-2-57 | |
| PHYSICIAN'S NAME (Type) CHESTER Z. HAVERBACK, M. D. | | | | National Institutes of Health Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 5, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Prince Geo. Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey | | | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR DATE 6-5-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bernie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06585

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6598

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 98 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | |
| d. STREET ADDRESS 1656 West Virginia Ave., N.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Agnes Middle Catherine Last Vanne | | 4. DATE OF DEATH Month June Day 21 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 26, 1909 |
| 9. AGE (In years last birthday) 47 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier | | 10b. KIND OF BUSINESS OR INDUSTRY Unascertainable | |
| 11. BIRTHPLACE (State or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Schlosser | | 14. MOTHER'S MAIDEN NAME Catherine Loehman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 15, 1957 , to June 21, 1957 , that I last saw the deceased alive on June 21, 1957 , and that death occurred at 6:00 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED S. Weissman M.D. The Clinical Center 6/21/57 National Institutes of Health Bethesda 14, Maryland | | | |
| 22. BURIAL, CREMATION, REMOVAL (Specify) 24 June 57 | | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery Wash. DC | |
| 22d. LOCATION (City, town, or county) (State) | | 23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home H + more care n e pc | |
| 24a. REC'D BY REGISTRAR 6-25-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | |
|---------------------------------|--|----------------------------|--|
| DECEASED | | DATE OF DEATH | |
| NAME | | AGE | |
| SEX | | RACE | |
| BIRTH DATE | | BIRTH PLACE | |
| MARRIAGE DATE | | MARRIAGE PLACE | |
| OCCUPATION | | EDUCATION | |
| RESIDENCE | | PLACE OF DEATH | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| DATE | | TIME | |
| PLACE | | CITY | |
| STATE | | COUNTY | |
| FEDERAL BUREAU OF INVESTIGATION | | U.S. DEPARTMENT OF JUSTICE | |
| WASHINGTON, D.C. | | 20535 | |

Handwritten notes and signatures are present throughout the form, including a large signature in the center and various stamps at the bottom.

BUREAU V. S.

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6599

CERTIFICATE OF DEATH

06586

Reg. Dist. No. 216

| | | | | |
|---|---|---|--|----------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE X2</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | d. STREET ADDRESS <u>4713 DRUMMOND AVE</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>JOHN C. WALKER</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1957</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR-6-1897</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>APPRAISER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u> | 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>10</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. <u></u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>JOHN C. WALKER</u> | | 14. MOTHER'S MAIDEN NAME <u>JENNIE YOUNG</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> 19 <u>17</u> - | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | |
| 17. INFORMANT <u>CLAXTON WALKER-SON</u> | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma and Insufficiency</u> <u>581.0</u> DUE TO <u>Portal cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>446x Arteriosclerotic Nephrosclerosis</u> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month <u>19</u> Day <u>15</u> Year <u>1957</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 15, 1957</u> to <u>June 16, 1957</u> , that I last saw the deceased alive on <u>June 15, 1957</u> , and that death occurred at <u>9:35 PM</u> , from the causes and on the date stated above. | | | | |
| ACTUAL SIGNATURE <u>George A. Grey, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>104 Chevy Chase Drive</u> DATE SIGNED <u>6/16/57</u> | | |
| PHYSICIAN'S NAME (Type) <u>George A. Grey, Jr.</u> | | <u>Cherry Chase 15 Maryland</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/18/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Prince George Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 6-24-57</u> | | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | |

RECEIVED

6600

CERTIFICATE OF DEATH

Reg. Dist. No.

218

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN 1b 2 yrs 11½ mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Rookdale 03x22) | |
| f. STREET ADDRESS 8338 Liberty Road | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Margaret Last Ward | | 4. DATE OF DEATH Month June Day 28 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 27, 1879 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Rockdale, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Martin Luther Jean | | 14. MOTHER'S MAIDEN NAME Katherine Rebecca Lynch | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Asbury Home records | | Address Gaithersburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension Cardiovascular heart disease DUE TO (c) hypertension | | | |
| INTERVAL BETWEEN ONSET AND DEATH 4 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-24 , 19 57 , to 6-28 , 19 57 , that I last saw the deceased alive on 6-28 , 19 57 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4208 ANTHONY ST Hensington Md. DATE SIGNED 6-28 | | | |
| ACTUAL SIGNATURE Sarah E. Glover | | M.D. 4208 ANTHONY ST Hensington Md. | |
| PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/15/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem. | | 22d. LOCATION (City, town, or county) (State) Randallstown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons - Balto | | 24a. REC'D BY REGISTRAR JUL 1 1957 | |
| 24b. REGISTRAR'S SIGNATURE Glover | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|-----------------|--|-----------------|--|------------------|--|---------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1928 | | MOBILE, ALABAMA | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | DATE OF DEATH | | PLACE OF DEATH | |
| MEMBER OF ARMY | | HIGH SCHOOL | | MARRIED | | METHODIST | | APRIL 4, 1968 | | MEMPHIS, TENNESSEE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | | REGISTRATION NO. | | FILING NO. | | FILING DATE | |
| SHOOTING | | HOMICIDE | | 100-443886 | | 100-443886 | | 100-443886 | | APRIL 10, 1968 | |

*Central American - accident
 Hypertension - Central American - accident*

BUREAU V. H.

RECEIVED

James E. Allen

100-443886

6-58

APR 10 1968

6601

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | |
|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9027 GEORGIA AVE</u> | | | d. STREET ADDRESS <u>1 9027 GEORGIA AVE</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>LEWIS</u> Last <u>WATERS</u> | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1957</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 19, 1880</u> | 9. AGE (In years lost birthday) <u>76</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL MERCHANT</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MALE CLOTHING</u> | | 11. BIRTHPLACE (State or foreign country) <u>EDMON, MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>THOS. WATERS</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>MARTHA DAWSON</u> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u> | | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | | 17. INFORMANT Address <u>SILVER SPRING MD</u> <u>ALICE HENRIETTA WATERS 9027 GEORGIA AVE</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>931X cerebro-vascular accident</u> DUE TO (b) <u>cerebro-arteriosclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 WKS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>612X Prostatic resection April 1957</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>Nov. 1956</u> to <u>JUNE 25, 1957</u> that I last saw the deceased alive on <u>6-24</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Wm. M. Ballinger</u> M.D. | | ADDRESS (Street, city or town, state) <u>1801 Eye N.W. WASH. DC</u> | | DATE SIGNED <u>6-25-57</u> | |
| PHYSICIAN'S NAME (Type) <u>WM. M. BALLINGER</u> | | 1801 EYE ST. N.W. WASH. DC | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) | (State) | |
| <u>BURIAL</u> | <u>JUNE 27, 1957</u> | <u>UNION CEMETERY</u> | <u>BURTONSVILLE, MONTGOMERY</u> | <u>MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> | | ADDRESS <u>DC</u> | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE <u>—</u> | |
| <u>254 CARROLL ST. NW</u> | | <u>DC</u> | <u>JUN 28 1957</u> | <u>Francis P. Patten</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11-1-57

11-1-57

11-1-57

11-1-57

11-1-57

11-1-57

BUREAU V. S.

JUN 28 1957

RECEIVED

6459

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | | c. LENGTH OF STAY IN TB <i>15 days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Son & Hosp.</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>John Frederick Warfield</i> | | | | 4. DATE OF DEATH <i>June 2 1957</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>CAUC</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9/29/82</i> | 9. AGE (In years last birthday) <i>74</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>electrical contractor Self-employed</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>MD.</i> | | 11. BIRTHPLACE (State or foreign country) <i>MD.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | | | | | | | |
| 13. FATHER'S NAME <i>John Albert Warfield</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Ellen Stunkle</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | 16. SOCIAL SECURITY NO. <i>Hosp Records</i> | | | |
| 17. INFORMANT <i>Hosp Records</i> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarct of lungs, recent</i> <i>465X</i> DUE TO <i>Embolic of pulmonary arteries</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>465X</i> DUE TO (b) <i>Embolic of pulmonary arteries</i> (c) <i>Embolic of pulmonary arteries</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>few days</i> <i>" "</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Heart Disease of uncertain type (? endocardial fibroelastosis)</i> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <i>Mar. 10 1957</i> to <i>June 2 1957</i> , that I last saw the deceased alive on <i>June 2 1957</i> , and that death occurred at <i>1:40 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Charles W. Harnsberger</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>4201 NEW HAMPI. AVE. N.W.</i> | | | |
| DATE SIGNED | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>CHAS. W. HARNBERGER WASHINGTON D.C.</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 22b. DATE THEREOF <i>6/5/57</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i> | 22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE COUNTY, MD.</i> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i> | | | | ADDRESS <i>SILVER SPRING, MD</i> | | 24a. REC'D BY REGISTRAR <i>J. M. Dodd</i> | 24b. REGISTRAR'S SIGNATURE <i>J. M. Dodd</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 10 1957

RECEIVED

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montg MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmount | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmount, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 6430 Brooks Lane | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Emma Middle Rose Last Watkins | | 4. DATE OF DEATH Month June Day 14 Year 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug 21-1874 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home Work | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md, | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Basil Buxton | | 14. MOTHER'S MAIDEN NAME Lavenia Brandenburg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs John H. Shuemaker. | | Address 6430 Brookslane Washing 16 D C, | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arteriosclerosis, Hypertension, 3 years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 12 , 19 57 , to June 14 , 19 57 , that I last saw the deceased alive on June 12 , 19 57 , and that death occurred at 6:17 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5120 Rese Center Rd. Washington D.C. DATE SIGNED 6/14/57 ACTUAL SIGNATURE Andrew E. Rudnai M.D. PHYSICIAN'S NAME (Type) ANDREW E. RUDNAI Washington D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-16-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Montgomery | | 22d. LOCATION (City, town, or county) (State) Damascus Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md. | | 24a. REC'D BY REGISTRAR DATE 6-18-57 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---------------------------------------|--|--|--|--------------------------------|--|--|--|---|--|------------------------------------|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | | 4. DATE OF BIRTH Jan 5, 1928 | | 5. PLACE OF BIRTH Jackson, Mississippi | | 6. OCCUPATION None | |
| 7. MARITAL STATUS Single | | 8. COLOR White | | 9. HEIGHT 5' 10" | | 10. WEIGHT 175 | | 11. BUILD Slender | | 12. EYES Blue | |
| 13. HAIR Brown | | 14. COMPLEXION Fair | | 15. TENDENCY TO BLEED No | | 16. DISEASES None | | 17. CAUSE OF DEATH Gunshot wound | | 18. MANNER OF DEATH Suicide | |
| 19. DATE OF DEATH June 4, 1968 | | 20. PLACE OF DEATH Memphis, Tennessee | | 21. TIME OF DEATH 2:01 PM | | 22. SIGNATURE OF DECEASED None | | 23. SIGNATURE OF WITNESS None | | 24. SIGNATURE OF PHYSICIAN None | |
| 25. SIGNATURE OF REGISTRAR None | | 26. SIGNATURE OF CLERK None | | 27. SIGNATURE OF JUDGE None | | 28. SIGNATURE OF DISTRICT ATTORNEY None | | 29. SIGNATURE OF SHERIFF None | | 30. SIGNATURE OF CORONER None | |

BUREAU V. 3

JUN 20 1968

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6603

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06591

Reg. Dist. No.

214

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN lb DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FRANKLIN & WIRE AVE. at Bus Stop | | | | d. STREET ADDRESS 9113 WIRE AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HERBERT Middle A Last WATKINS | | | | 4. DATE OF DEATH Month JUNE Day 13 Year 19 57 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/31/03 | |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DELIVERY CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop Department Store | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HERBERT A. WATKINS | | | | 14. MOTHER'S MAIDEN NAME MARY ELLEN CALLAHAN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 577-10-6152 | | 17. INFORMANT Address Miss Regina C. Watkins, 9113 Wire Ave. Silver Spring, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/15/57 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Rood Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey | | | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR DATE 6/17/57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Francis Lott | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|-----|--|-----|--|------|--|----------|--|----------|--|-----------|--|------------|--|-----------|--|---------------|--|----------------|--|----------------|--|-----------------|--|-----------------------|--|-------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | RESIDENCE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | | DATE | |
| JAMES H. HARRIS | | 45 | | M | | W | | C | | M | | H | | H | | H | | JUN 15 1957 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | J. H. HARRIS | | JUN 15 1957 | |

BUREAU V. S.

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6604

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06592

Reg. Dist. No.

| | | | |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Albany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 1 day | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNH, NNMC, BETHESDA, MARYLAND | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Arthur Middle William Last WERTMAN | | 4. DATE OF DEATH Month June Day 15 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 May 1936 |
| 9. AGE (In years last birthday) 21 yrs. | | 10. IF UNDER 1 YEAR Months 21 Days 15 Hours 15 Min. 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Arthur WERTMAN | | 14. MOTHER'S MAIDEN NAME Thelma VALLES | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 4-12-56-6-15-57 112 30 6490 | |
| 17. INFORMANT Official Navy Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of C-5 with laceration of cord DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 24 hours 42 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dived from eight foot board into shallow water while swimming | |
| 20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 6-13 1957 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Timberlake | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oaktone | | 20f. (City or town) (County) (State) Virginia | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | DATE SIGNED 16 June 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-21-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Saint Matthews Cemetery | | 22d. LOCATION (City, town, or county) (State) Buffalo New York | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | ADDRESS 7557 Wisconsin Ave., Bethesda, Md | |
| 24a. REC'D BY REGISTRAR 6-17-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Garselly | |

MARYLAND STATE OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|-------------------|--|---------------------|--|----------------------|--|
| NAME (PRINT) | | LAST NAME | | FIRST NAME | | MIDDLE NAME | |
| AGE | | SEX | | RACE | | RELIGION | |
| DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | |
| TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | |
| SIGNATURE OF EXAMINER | | TITLE OF EXAMINER | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | |

BUREAU V. 2

JUN 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6605

CERTIFICATE OF DEATH

Reg. Dist. No.

06593

214

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 1 Silver Spring</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover, Md.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Rest Home, RD 1, Silver Spring</u> | | | | d. STREET ADDRESS <u>1107 Ardwick Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Blanche White</u> | | | | 4. DATE OF DEATH <u>6-25-1957</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-2-93</u> | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Anderson S.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Hawthorne Brown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Medical Records</u> Address <u>Mont. County H.D.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, Ankylosing of Spine, Chronic Con. Fail.</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>725X</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>3-17-57</u> , to <u>6-25-57</u> , that I last saw the deceased alive on <u>6-19-57</u> , and that death occurred at <u>7:10</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>RD 1 Gaithersburg, Md.</u> | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>CLIVE E. JACKSON</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 22b. DATE THEREOF <u>6-25-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle Rollins</u> | | | | ADDRESS <u>4339 Hunt Rd.</u> | | 24a. REC'D BY REGISTRAR <u>6/30/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|-------------------------------|--|-------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|-------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF DECEASED | | 13. SIGNATURE OF WITNESSES | | 14. SIGNATURE OF FUNERAL HOME | | 15. SIGNATURE OF CLERGY | | 16. SIGNATURE OF OTHER | | 17. SIGNATURE OF OTHER | | 18. SIGNATURE OF OTHER | | 19. SIGNATURE OF OTHER | | 20. SIGNATURE OF OTHER | | 21. SIGNATURE OF OTHER | | 22. SIGNATURE OF OTHER | | 23. SIGNATURE OF OTHER | | 24. SIGNATURE OF OTHER | | 25. SIGNATURE OF OTHER | | 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | | 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | | 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | | 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | | 36. SIGNATURE OF OTHER | | 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | | 40. SIGNATURE OF OTHER | | 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | | 43. SIGNATURE OF OTHER | | 44. SIGNATURE OF OTHER | | 45. SIGNATURE OF OTHER | | 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | | 49. SIGNATURE OF OTHER | | 50. SIGNATURE OF OTHER | | 51. SIGNATURE OF OTHER | | 52. SIGNATURE OF OTHER | | 53. SIGNATURE OF OTHER | | 54. SIGNATURE OF OTHER | | 55. SIGNATURE OF OTHER | | 56. SIGNATURE OF OTHER | | 57. SIGNATURE OF OTHER | | 58. SIGNATURE OF OTHER | | 59. SIGNATURE OF OTHER | | 60. SIGNATURE OF OTHER | | 61. SIGNATURE OF OTHER | | 62. SIGNATURE OF OTHER | | 63. SIGNATURE OF OTHER | | 64. SIGNATURE OF OTHER | | 65. SIGNATURE OF OTHER | | 66. SIGNATURE OF OTHER | | 67. SIGNATURE OF OTHER | | 68. SIGNATURE OF OTHER | | 69. SIGNATURE OF OTHER | | 70. SIGNATURE OF OTHER | | 71. SIGNATURE OF OTHER | | 72. SIGNATURE OF OTHER | | 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | | 76. SIGNATURE OF OTHER | | 77. SIGNATURE OF OTHER | | 78. SIGNATURE OF OTHER | | 79. SIGNATURE OF OTHER | | 80. SIGNATURE OF OTHER | | 81. SIGNATURE OF OTHER | | 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | | 85. SIGNATURE OF OTHER | | 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | | 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | | 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | | 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | | 96. SIGNATURE OF OTHER | | 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | | 100. SIGNATURE OF OTHER | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|-------------------------------|--|-------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|-------------------------|--|

BUREAU V. 21

1 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06594

Reg. Dist. No.

214

| | | | | | |
|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | c. LENGTH OF STAY IN TB D.O.A. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B & O RR tracks near N. Lakeland R R Bridge | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 4. DATE OF DEATH First Sandy Middle White Last Month 6/7/57 Day 19 Year | | | 5. SEX male 6. COLOR OR RACE ool 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 3/5/1884 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) N.C. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mary White | | | Address 11-3 5th St, N. W. Wash. D. C. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral and Thoracic Hemorrhage 802x DUE TO Fracture of skull and Crushed chest (rt) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound Fracture of rt elbow (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compound Fracture of rt elbow | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently struck by train while sitting along RR tracks | | |
| 20c. TIME OF INJURY Month, Day, Year 1 hour a. m. 6/7/57 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B&O RR | | | 20f. (City or town) (County) (State) Silver Spring Montg. Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | DATE SIGNED 6/7/57 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6/7/57 | | 22c. NAME OF CEMETERY OR CREMATORY Morris Carter Funeral Home, Washington, D. C. | |
| 22d. LOCATION (City, town, or county) (State) | | 23. FUNERAL DIRECTOR'S SIGNATURE Robert K. Snowden ADDRESS Rockville, Md. | | | |
| 24a. REC'D BY REGISTRAR JUN 13 1957 | | 24b. REGISTRAR'S SIGNATURE Frances Potter | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|-------------------------------------|--|--|--|---|--|
| Name of Deceased Silver, William | | Sex Male | | Age 35 | | Date of Death 5/5/1957 | |
| Place of Birth Baltimore, Md. | | Race White | | Occupation None | | Cause of Death Fracture of skull and cerebral artery (a) | |
| Residence 1105 Elm St., Bk. | | Marital Status Single | | Date of Birth 5/5/1922 | | Manner of Death Accident | |
| Signature of Medical Examiner [Signature] | | Signature of Coroner [Signature] | | Signature of Police Officer [Signature] | | Signature of Witness [Signature] | |
| Date of Examination 5/5/1957 | | Time of Examination 10:00 AM | | Place of Examination Baltimore, Md. | | Signature of Physician [Signature] | |

Approximate amount of brain tissue missing along R.R. group

Complete fracture of skull

RECEIVED
JUN 13 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06595

6607

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 405 Pershing Drive | | d. STREET ADDRESS 405 Pershing Drive | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Elizabeth Agnes Foley Wilcox | | 4. DATE OF DEATH Month June Day 20 Year 19 57 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/8/1900 |
| 9. AGE (In years lost birthday) 57 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C. | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Thomas F. Foley | | 14. MOTHER'S MAIDEN NAME Elizabeth Connell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Francis M. Wilcox | | Address 405 Pershing Drive Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 hrs | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 19 40 to June 20 19 57 , that I last saw the deceased alive on June 20 19 57 , and that death occurred at 2:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6480-N.W. Ave Takoma Park, Md. DATE SIGNED | | | |
| ACTUAL SIGNATURE R. C. Kirchner | | M.D. 6480-N.W. Ave | |
| PHYSICIAN'S NAME (Type) R. C. KIRCHNER | | Takoma Park, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/24/1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Prince Georges County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. | | ADDRESS 2901 14th St., N.W. DC | |
| 24a. REC'D BY REGISTRAR June 21 1957 | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

6608

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY Fairfax | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WAYNE 432 Argyle Drive, Falls Church 75x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium and Hospital | | d. STREET ADDRESS 336 CONESTOGA ROAD 12101 Columbia Pike | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Richard Francis Wood, Jr. | | 4. DATE OF DEATH Month Day Year June 20 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 1, 1885 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Broker—retired | | 10b. KIND OF BUSINESS OR INDUSTRY retired | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard Francis Wood | | 14. MOTHER'S MAIDEN NAME Mary E. Leaming Surname—Leaming | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Mexican - 1st World | |
| 17. INFORMANT Edwin Bonsack, Jr., 432 Argyle Drive, - Va. | | Address Falls Ch. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0 (b) Coronary Sclerosis (c) General arterio Sclerosis | | INTERVAL BETWEEN ONSET AND DEATH a few minutes 2 2 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arterio-sclerosis & psychosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1, 1957 , to June 20, 1957 , that I last saw the deceased alive on June 19, 1957 , and that death occurred at 10:40 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Alvin J. Kistler | | DATE SIGNED June 20, 1957 | |
| PHYSICIAN'S NAME (Type) Alvin J. Kistler, M. D. | | ADDRESS Cedarcroft San. & Hosp. Silver Spg. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. & Burial | | 22b. DATE THEREOF 6/24/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Old Saint David's Cemetery | | 22d. LOCATION (City, town, or county) (State) Devon, Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey | | 24a. REC'D BY REGISTRAR SILVER SPRING, MD. | |
| 24b. REGISTRAR'S SIGNATURE James C. Potter | | DATE July 1, 1957 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6609 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06596

Reg. Dist. No. 286

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>1 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6901 Armat Dr.</u> | | | | d. STREET ADDRESS <u>6901 Armat Dr.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Maria Beaud Wornell</u> | | | | 4. DATE OF DEATH Month Day Year <u>6-19-57</u> 19 | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>7-27-80</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Christian Scientist practitioner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | | 11. BIRTHPLACE (State or foreign country) <u>M.D.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Stephen Beaud</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mattie Woodward</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>Mary W. Edwards - Sister</u> Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Cardiac - renal disease</u> (c) <u></u> DUE TO <u></u> cause lost. <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | | 20f. (City or town) (County) (State) <u></u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>6-19-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Switzland M.D.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler Sons</u> ADDRESS <u>1756 Penna Ave. NW</u> | | | | 24a. REC'D BY REGISTRAR <u>Benie M. Thompson</u> DATE <u>6-21-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Benie M. Thompson</u> | |

DATE SIGNED

6-19-57

STATE DEPARTMENT OF HEALTH - ALABAMA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 24 1957

RECEIVED

6610

CERTIFICATE OF DEATH

Reg. Dist. No.

218

| | | | |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montg MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. | | c. LENGTH OF STAY IN 1b 25yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Gaithersburg | |
| 3. NAME OF DECEASED (Type or print) Lydia Anna Younkings | | d. STREET ADDRESS 14 E. Diamond Ave | |
| 4. DATE OF DEATH Month June Day 17 Year 1957 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec 7-1888 |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home Work | |
| 11. BIRTHPLACE (State or foreign country) Middletown. Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Martin L. Flook | | 14. MOTHER'S MAIDEN NAME Sarah Jennings | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT L. Reynolds Younkings. Gaithersburg. Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIAL HYPERTENSION DUE TO (c) ARTERIO SCLEROSIS | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 10 YRS 10 & 12.5. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0 NONE | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JUNE 1, 1957 to JUNE 17, 1957 that I last saw the deceased alive on JUNE 17, 1957 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1 June 1957 | | | |
| ACTUAL SIGNATURE Gordon S. Rosenberger M.D. | | PHYSICIAN'S NAME (Type) Gordon S. Rosenberger Gaithersburg. Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-19-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | | 22d. LOCATION (City, town, or county) (State) Middletown. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg. Md. | | 24a. REC'D BY REGISTRAR DATE June 18-57 | |
| 24b. REGISTRAR'S SIGNATURE Alfred L. Coole | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

JUN 21 1957

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED